THE INTEGRATION OF SPIRITUALITY IN MEDICINE IN A HEALTHCARE SETTING: AN INTERDISCIPLINARY APPROACH

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ABSTRACT

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When faced with a health crisis, people tend to take stock of their lives, and ask profound existential, theological and spiritual questions. Fear, loss of control, vulnerability, mortality, alienation, loneliness, suffering, anxiety, guilt, sadness, despair, isolation are some issues that confront the infirm. These emotions contribute to and are often worse than the illness itself. However, they are difficult to quantify and as a result they are often ignored by a medical system that is based primarily on scientific research. The idea for this demonstration project grew in an unlikely setting: an HMO. An executive who learned from personal experience the role of spiritual care in the hospital decided to make it his mission to provide pastoral care services to all HMO members. From that grew the HIP Integrative Wellness Department, and an opportunity to offer educational and training resources for medical providers regarding the role of spirituality in creating health and illness.

This paper describes the process of setting up and managing the Spirituality and Medicine initiative at Health Insurance Plan of New York (HIP). There were many obstacles to overcome, including the cultural split between science and religion, the time constraints of medical providers, the defensiveness and mistrust that often exists between the scientific community and the religious community, and administrative and philosophical changes within the organization. Despite and because of the challenges, the Spirituality and Medicine program is one that has responded to the voiced needs of

medical providers and their patients for a model of care that incorporates body, mind and spirit in the process of healing.

The initial chapter describes the structure of HIP and how the Integrative Wellness Department was formed. Ensuing chapters describe the Spirituality in Medicine initiative, comparable ministries that resourced its development, the role of the site team in moving the project forward, candidate competencies, and the plan of implementation for the project. One of the primary challenges described involves how as the structure and leadership of HIP changed, the plan of implementation also had to respond and transform to create a program that like its constituency is inclusive culturally, religiously, and theologically.

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INTRODUCTION

> Now there was a woman who had been suffering from hemorrhages for twelve years. She had endured much under many physicians and had spent all that she had; and she was no better, but rather grew worse. She had heard about Jesus and came up behind him in the crowd and touched his cloak, for she said, "If I but touch his clothes, I will be made well." Immediately, her hemorrhage stopped; and she felt in her body that she was healed of her disease. Immediately aware that power had gone forth from him, Jesus turned about in the crowd and said, "Who touched my clothes?" And his disciples said to him, "You see the crowd pressing in on you; how can you say, 'Who touched me?'" He looked all around to see who had done it. But the woman, knowing what had happened to her, came in fear and trembling, fell down before him, and told him the whole truth. He said to her, "Daughter, your faith has made you well; go in peace, and be healed of your disease.

Mark 5:25-34
The New Revised Standard Version

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"The spiritual dimension cannot be ignored, for it is what makes us human."
Viktor E. Frankl
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I was born in the Philippines, a country that is predominantly Roman Catholic. It is a nation with eclectic religious practices, some of them bordering on the superstitious. While doctors and traditional medicine are respected, alternative methods of treatment are also popular. Faith-healers, belief in miracles and the power of faith are considered mainstream.[1]

I grew up in a line of faith. My grandfather and father were pastors. My other relatives were people of deep faith and religious vocation. In such a context, there was a notion of God's love and power that did not preclude the miraculous. God could work wonders. But there was no simple assurance of well-being for the faithful. Early in my life, my grandmother, aunt and cousins were victims of a ferry disaster in the Philippines. They all were drowned or were devoured by sharks. My father, a man of faith who devoted his life in ministry was stricken with cancer. In spite of his faith and countless prayers on his behalf, he died. As I have witnessed the lives and deaths of my extended family, the question of spirituality and health has been intertwined. My brother-in-law died of colon cancer at 40. My father-in-law died after a bout with Alzheimers. My sister-in-law died at 54 from ovarian cancer, on and on, I can account for untimely deaths and undeserved sufferings, including those of patients I attended to in my chaplaincy. The capricious and random nature of life and death has been manifest. What role did spirituality play in the progression of the diseases and the demise of my loved ones? The question has been more than an intellectual exercise.

At the same time, I have witnessed and heard tales of reversal and remission. Some have told of the disappearance of tumors and the sudden recovery from terminal conditions. My mother was diagnosed with stage four inoperable lung cancer. At 75

[1] The introduction is adapted from the exegetical paper that was part of the proposal for this project.

years of age her prognosis was grim. According to statistics, she had between four to six months to live. After chemo-therapy, her cancer disappeared. It has been two years since her diagnosis and all she suffers is a slightly high cholesterol level. What was the role of spirituality in the diagnosis, the progression, the outcome? So I have been an intimate observer of the vicissitudes of life and the randomness of health crises. The failure of faith to restore loved ones has been a reminder that death and suffering come to every household, whether we want that or not. But the stories of transformation and life-saving surprises have presented a glimmer of exceptional hope. The dilemma of the spirit in the onset and treatment of disease has been a personal issue because of family events.

The Biblical story above serves as the backdrop, inspiration, catalyst and foundation on which this project will be built. First of all, it has personal fascination for me as woman. What would it be like to have a hemorrhage of blood for twelve years? It is bad enough to have monthly cycles--to experience the personal discomfort and inconvenience of a menstrual period. Even today, there are misconceptions, misunderstandings and myths surrounding those periods. The mood swings are stereotyped and are the subject of jokes. There are crude allusions to women who are having their periods, and there is still an amount of embarrassment and humiliation surrounding the occurrence for some women. What must it have been like for the woman, frustrated, marginalized, ostracized? It might be easier for me to empathize as a woman since vestiges of the social stigma remain.

On the other hand, I am relatively healthy at "middle age." Until recently, I have not suffered a chronic illness, nor been sick for a long period of time. I have not known the depressive effects of a lingering or prolonged illness. Medical care has always been

available to me, and treatment has been prompt and competent. Now that I work for a managed care insurer, I have the top-of-the-line coverage. I have a thorough and proficient primary care physician, who schedules multiple tests for proper diagnosis. So even with a recent diagnosis of thyroid cancer and diabetes, I have treatment and care that maintain me as fully functional and in better physical condition because of medical advancement and modern technology.

Being middle class, I do not have to suffer from inadequate medical care. Good care is readily available. Though I have been fortunate, some in my family have died from poor physician care. My spouse's grandmother died from cancer when her physician dismissed her symptoms as "psychosomatic," a product of her mental state. My spouse's mother also died from malpractice when a psychiatrist refused to explore the cause of abnormalities in her blood. So while I personally have been immune from the effects of poor medical care, I have not been shielded from the fact that it happens all too often. And there is much controversy surrounding allegations that the medical community spends money on research to treat symptoms, but not necessarily to cure disease.

Vocationally, the scripture is at the heart of my professional call and career. Extensive clinical pastoral education has enabled me to detect or discern spiritual roots of some maladies. The severity – if not the onset – of many illnesses can be traced to the spirit or psyche. Immersion in the chaplaincy helped to broaden my understanding of health and wellness to include the spiritual, emotional and psychological dimensions. My learning about sickness and health was holistic. I experienced the influence of spirituality on health and wellness as I ministered to patients and observed their progress.

When the Reverend Carl Flemister and I initiated spiritual care for Health Insurance Plan of Greater New York (HIP), a managed care organization, the linkage between spirit and health became my profession. The spiritual ingredient to health and healing is fundamental to the task of the volunteer hospital visitors that I trained and supervised. The spiritual is integral to the Integrative Wellness Department. It is critical to my job description. Our department is in tune with Harvard Medical School's program which addresses the relationship of health and the spirit. All of our business is determining how spirit and body, theology and medicine, interrelate and how healing can be affected and facilitated by treatment of the spirit. It is more than an academic exercise. It is a life-work.

How do I get medical professionals to recognize the influences of the spiritual on a patient? How do I equip doctors to recognize the possibility of spiritual pain and the potential of spiritual healing? What resources can be utilized to combine the modern practice of medicine with concepts of spirituality? How does physical healing intersect with spiritual healing?

This study comes in the middle of a renewed investigation into the efficacy of prayer on healing and interest in the relationship of mind and body. Recent articles in popular newsstand magazines have surveyed the attitudes of Americans on the role of the spirit in physical well-being and the belief in the ramifications of faith.[2] What is superstition and what is religion? Are faith-healers, alternative and complementary medicine mainstream? Is spirituality new age or old world? The theme of the scripture is

[2] *Time*, 24 June 1996. *USA Weekend,* 5-7 April 1996.

at the cutting edge of our cultural conversation and is at the heart of what I do as Director of Integrative Wellness at HIP Health Plan of New York.

Health care is the burning topic of our society, perhaps more immediate than the economy, education or terrorism. All around there are victims of the American health care system. Workers are being forced to pay more and more for their medical coverage – more of the premium and larger co-pays. Millions of Americans, many of them children, are not covered by medical insurance because of the high cost of premiums. Premiums increase in double digits from year to year. The cost of prescriptions forces the elderly into poverty. If you want to observe the effect of health policy, stand by a pharmacy counter at a drug store. Listen to the anger of those who pay exorbitant prices for drugs or who get rejected by the pharmacist. Only lately has the Bush administration taken steps to alleviate the problem, and only in the context of their motivation to help the drug industry and insurers.

The quality of medicine practiced is still suspect, especially for those of little means. The situation of the woman with the hemorrhage in the Biblical tale above is not that much of an exception, today. Many have spent all they have on doctors to no avail. Every family has personal horror stories of malpractice or inadequate care. Who cannot sympathize with the woman who went broke looking for a remedy? In the midst of the frustration have risen many quacks, alternative medicines and experimental remedies. Many resort to the internet for remedies, information and advice which their doctors don't have time to give them. Anger, fear, frustration, and desperation are not uncommon among those who are chronically ill and those who care for them.

While society is critical of the establishment - colonoscopies rationed because of cost, flu vaccines in short supply, liability insurance driving doctors out of practice, cheaper drugs over the border – there is no consensus as to a solution. The populace is uncertain of the role of the spirit in the remedy. Do you need to know Jesus to be cured? Is the spirituality that is therapeutic a potential in each and every person? Is it always random or is there cause and effect? The place of the spirit in a discredited or suspect medical environment is a current debate as well as a scriptural study.

The very first thing that struck me when I read the passage was how Jesus had gained celebrity status. He traveled with an entourage (his disciples) and was surrounded by a "great crowd" (vs. 21). This image portrays how inaccessible he must have been in the midst of his busy schedule, the thick crowd that surrounded him and the screening and scrutiny of his disciples. This reminds me of how difficult it is to make an appointment with doctors who oftentimes are over-booked, overwhelmed by quotas and paper-work. The red-tape one has to go through to get authorization for a procedure that is already covered by medical insurance, the cold, impersonal and often dismissive medical staff, all the unfair treatment just to get medical attention came to the fore. What does it take to get medical attention these days? Can one expect courteous, polite service?

The scripture passage speaks to us in several ways today. It tells us that God desires wellness. Our God cares about the physical well-being of creation. God is not oblivious to suffering, not insensitive to our sickness, not uncaring of our physical states. God is not above it all, transcendent and unfeeling. God wants us to be healthy. There is empathy and sympathy on God's part. God cares for the individual as well as for

humankind. This miracle story makes it plain. There was the attentive crowd, but Jesus noticed the single victim. God is cognizant of our particular trials and troubles. God is not overwhelmed by the multitude, but remains sensitive to the hurts of each one. That is reassuring in a world where so many seem overlooked, invisible, outnumbered, unnoticed, anonymous. To God, we're not just a policy number, not just "the uterine bleed on room 213, bed B." To God we are nearest and dearest, known by name; God even knows the number of hair on our heads.

As soon as the woman touched Jesus' garment, she was immediately healed (vs.30a). Consequently, Jesus felt the "power" leave him and he asked his disciples who touched him (vs. 30b). Grant states that: "Some modern healers maintain that they can feel a power flowing through, rather than from, their hands or bodies when they touch their patients, though the old Greek commentators insisted that the power in this case was not physical."[3] If this is the case, the faith of the woman is of critical significance. Jesus pointed to the woman's own faith and not to his own power to heal that cured the woman. As Grant points out: "Not that he [Jesus] held any modern idea of the psychological or auto suggestive power of faith: instead faith was the necessary condition for healing, which came from God (as in vs. 19).[4] According to the text, faith is the prerequisite for healing.

The dilemma of Jesus is that of each minister, lay or ordained and any caregiver, professional or otherwise. When we care for another, when we give of ourselves in service, it takes something out of us. It is depleting. If it is counsel, aid or simply presence, whatever we give in sacrifice is felt as a loss. It does not come without a cost.

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[3] Frederick C. Grant, *The Interpreter's Bible Vol VII* (New York: Abingdon Press), 1952, 720. J.A. Cramer, *Catenae in Evangelia,* (Oxford: S. Mathaei et S. Marci), 1840, 320
[4] Ibid., 722.

That reinforces the need for self-care and the conviction that the caregiver must find ways to renew, replenish, regain resources and learn tools for service. It is our sacred responsibility. The servant needs nurture. Just as financial institutions need an influx of cash in order to continue contributions, so the caregiver needs a fresh infusion of spiritual resources to disseminate to others. There is no storehouse that does not need restocking. The spiritual may not be material, but it is real. The invisible has existence.

For me, there are two primary issues in the text that bear upon the project. First, disease and illness may have a spiritual origin and disease may have a spiritual component. The degree of suffering may include an element of spiritual malaise. The spirit may be a crucial ingredient in the composition of a person's condition. If the person is not well, there may be spiritual causes and spiritual repercussions. The second issue follows naturally from the first: The remedy for a disease may be spiritual as well as physical. The cure for an illness may be facilitated through spiritual means. Spiritual therapy and spiritual treatments may contribute to the return of health, either as contributors toward healing or as the cure. Traditional medicine, with surgery, drugs and therapies, may not be the only way to achieve well-being. Holistic healing is possible, maybe even essential.

If the spiritual component of the person may contribute to a their sense of well-being, and if spirituality may contribute to the treatment of disease, then it is essential to provide spiritual resources to practitioners. There needs to be integration of spiritual diagnosis and treatment in the medical protocol. There needs to be recognition of the spirit's importance and potential in the regimen. How does this critical ingredient of human health get to be a part of the medical community's understanding of spiritual

health and applied to the practice of modern medicine and insurances? How does spiritual care gain acceptance as a vital and central component of human health, not tangential or peripheral?

The scripture indicates that the spiritual component needs to be explored – not only in church, not only by chaplains, but in the larger medical community. As a staff member of a large medical insurer and a recipient of good medical care, I am grateful for medicine and practitioners. God has granted us the miracles of traditional medicine. But the scripture hints that there is more to be examined and explored outside of the traditional, beyond the vast field of science. Perhaps, I can identify, initiate, facilitate and process occasions and opportunities to say, "Your faith has made you well."

In spite of the growing belief among medical practitioners that God is an active participant in the health and healing process of their patients, many of them are still doubtful and circumspect about the efficacy and value of their patients' theological beliefs as these relate to their physical condition and overall sense of wellbeing.

The patients' desire and need for their doctors to acknowledge their belief that God can affect their health and healing, as evidenced in many studies, have given many of these medical practitioners some pause:

> According to a Newsweek magazine poll, 72 percent of Americans say they would welcome a conversation with their physician about faith; the same number say they believe that praying to God can cure someone – even if science says the person doesn't stand a chance.[5]

Other studies show that "sixty-four percent of Americans believe physicians

[5] Gloria Kalb, "Faith and Healing," *Newsweek*, 10 November 2003, 43-46.

should pray with their patients if asked."[6] But "only ten percent of doctors have done so."[7] According to Dr. Harold Koenig, "fourty-four percent of hospitalized patients considered faith as the most important factor in coping with illness and only nine percent considered physicians as a contributing factor."[8] In as much as these factors point to peoples' belief that God can heal them, I am more apt to dwell in the midst of the complexity of the human condition and the unfathomable mystery of God - where I can live comfortably with many of my unanswerable existential questions. Questions that fuel the fires of my faith include: Why are some people healed and not others? If one is not healed, does it mean that they do not have enough faith? During the Second World War, my father contracted malaria. His family evacuated to the foothills of their region to hide from Japanese soldiers. The place they settled in was far from any doctors or hospitals. There was no means of transportation save for a water buffalo-driven carriage. In the throes of convulsions and high fever, his mother prayed over him unceasingly, until his fever broke and eventually he got better. My grandmother and my father had the most profound faith I have ever known. So why did my grandmother drown when the inter-island vessel collided with an oil barge in the middle of the Pacific Ocean? And why did my father die of pancreatic cancer at the early age of 63? Was their faith not strong enough? Were my prayers to spare my father's life not as powerful as my grandmother's?

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[6] *Time*, 24 June 1996.
[7] *USA Weekend,* 5-7 April 1996.
[8] Harold G. Koenig, "Religious Perspective of Doctors, Nurses, Patients and Families," *Journal of Pastoral Care* 45, no. 3 (1991): 254-67.

Why are some prayers answered and not others? And "why, [indeed], do bad things happen to good people?"[9] There are people who do not believe in God, yet they get better and live long and healthy lives. Does God also heal these people in spite of their unbelief, as portrayed by the nine (save for one) lepers who did not come back to praise Jesus? (Luke 17:12-19).[10] The God of Job appears to be unjust, unreliable, sadistic. Did Job really deserve this hellish ordeal, this undeserved suffering? Is death a punishment or a failure on the doctors' part as construed by many of them in their field?

In spite of this *maelstrom* of questions and debates, many people still adhere to the notion that God not only can, but does, affect medical outcomes as indicated in the *Time* magazine survey:

> Eighty-two percent believe in the healing power of personal prayers; 72 percent believe that God can intervene to cure those with a serious illness and 73 percent believe that praying for another can help cure their illness.[11]

Many healing instances can be used to demonstrate that God is not the only source of healing. A chaplain from Bellevue Hospital in New York City told the HVP trainees that about a patient who was scheduled for surgery to remove a cancerous tumor the following day. She told the chaplain that she knew the cause of her disease. She went on to tell the chaplain that she wronged her best friend by sleeping with her husband and that she developed the tumor as a form of punishment. Upon hearing this, the chaplain asked the patient if she would consider asking the woman for forgiveness. The patient agreed and the chaplain facilitated the call. The woman also agreed to speak with the patient. A conversation ensued, the patient asked her friend for forgiveness and her

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[9] Harold Kushner, *When Bad Things Happen To Good People* (New York: Avon Books, 1981).
[10] The Revised Standard Version of the Bible.
[11] *Time,* 24 June 1996.

friend gave it. The next day, the patient was wheeled in for pre-operative surgery tests and they found that the patient's tumor had disappeared. This and many other similar stories can make one wonder if God always has a hand in the healing process.

Could there be other factors that impact on healing other than God? What of "faith healing?" Thousands of people journey to the Philippines to see faith healers. Do people achieve healing because they believe these faith healers possess special powers to heal them? Or do they believe that these healers are emissaries of God? Do people who do not believe in God believe in miracles? Can modern technology and scientific advancements be considered miracles? We can now make the lame walk, the blind see, raise people from the dead and even separate twins, transplant body parts, clone, etc., etc. Can these "miracles" be attributed to God? And what about geographical locations like Chimayo in Arizona or Lourdes in France; or icons, talismans, amulets? How about luck, chance, offering sacrifices, or hope, forgiveness, love? These are all considered healing agents for many people whether they believe in God or not.

What of spirituality as "Self transcendence which gives integrity and meaning to life by situating the person within the horizon of ultimacy…or the religious meaning of spirituality [as] based on the conception of what constitutes the proper and highest actualization of the human capacity for self-transcendence in personal relationships, namely, relationship with God?"[12] It is not God's existence or the belief that God affects the health and healing of people that is in question here, but whether faith in God or belief system should be acknowledged as a powerful, empirical healing agent and for that matter confirmed as an intrinsic component in the healing process.

[12] J. W. Conn, in *The New Dictionary of Theology*, (Collegeville, MN: The Liturgical Press, 1987), 108.

CHAPTER I

Introduction to the Setting: HIP/GHI/EmblemHealth

HIP Identity and History

Health Plan of Greater New York (HIP) is located at 55 Water Street in the heart of New York City's financial district. It is a managed care organization servicing the greater New York area for over 50 years, and the largest Heath Maintenance Organization (HMO) in New York City based on membership. HIP is the setting for this demonstration project.

HIP provides access to physician services and hospital care in a variety of ways. HIP contracts with more than 160 hospitals, including major acute care institutions, in New York, Connecticut and Massachusetts to provide services to its members. HIP members have access to HIP-contracted doctors in large, multi-specialty group practices and in facilities associated with some of New York's leading hospitals, as well as those practicing in their own offices. HIP acquired Vytra Health Plans in 2001; ConnectiCare, one of the largest health plans in Connecticut in 2005; and PerfectHealth in 2006. HIP's combined membership is approximately 1.4 million. HIP's total network, including subsidiaries, comprises nearly 43,000 physicians and other providers in over 72,000 locations in New York, Connecticut and Massachusetts.

HIP was established during the administration of Mayor Fiorello La Guardia, to specifically provide medical insurance coverage to government employees of New York

City. Now, HIP has been ranked number one among all insurance companies in the nation by Information Week in the use of innovative technology and is the first health care company in the nation to render its web site in English, Spanish, Chinese, and Korean with additional languages to come. HIP's participating providers have met HIP's strict credentialing criteria. In fact, its high standards have resulted in Commendable Accreditation from the National Committee for Quality Assurance (NCQA), the independent non-governmental agency that monitors and evaluates managed care organizations.[13]

HIP member care is orchestrated by the Primary Care Physician (PCP) with the goal of containing medical costs by assuring that the member receives needed care in the most appropriate setting based on the member's available benefits. The major purposes of a managed care organization are to: determine the most appropriate setting, determine the most appropriate treatment, identify quality of care issues, facilitate safe discharge and make sure benefits are being appropriately used. HIP, therefore, is not positioned to "deliver" care. Care is delivered by contracted network physicians and other healthcare providers.

As a managed care organization, HIP is a proactive, wellness oriented health care delivery system in which care is provided through a network of contracted facilities and providers. HIP embraces the belief that "a well rounded interdisciplinary care is beneficial to the overall health and wellbeing of the [its] members.[14] HIP maximizes the health of its members through providing preventative care with programs such as: routine physical exams, mammography, immunizations, flu shots smoking cessation programs

[13] "About HIP" www.hipusa.com (accessed April 2004).
[14] Ibid.

and programs offered by the Health Promotion and Disease Management and also Integrative Wellness Department, where I work as a Director.

In 2005, the boards of directors of HIP and GHI (Group Health Incorporated) agreed to a merger. Together, after the merger is complete, HIP and GHI will have more than 4 million members and offer about 90,000 providers in over 145,000 locations. In 2007, HIP accomplished much of the work on the merger with Group Health Incorporated (GHI), another not-for-profit insurer, forming EmblemHealth, Inc. to be the for-profit parent company of both entities. As a combined for-profit company, EmblemHealth claims that it anticipates having access to capital that will allow technology, infrastructure, product offerings, and customer service improvements that leadership has deemed necessary to be competitive in the years ahead.

GHI Identity and History

GHI (Group Health Incorporated) was established in 1937 as Group Health Association of New York, a small health cooperative. GHI is now the largest not-for-profit health insurance company in New York State, and provides services for more than 2.6 million individuals.

Historically, GHI has pioneered many programs that are now standard in the health insurance field. Nationwide, they were the first health services corporation selected as the single nationwide administrator for Coordination of Benefits (COB) for Medicare.

In 2007, GHI received some of the highest ratings for PPO health plans in the New York region in an annual evaluation by the National Business Coalition on Health.

GHI was ranked the highest and named the regional benchmark for the NY market in four areas: behavioral health, prevention and health promotion, pharmaceutical management, and consumer engagement.[15]

What the future holds after the HIP/GHI merger and transition away from for-profit status remains to be seen. The hope is that the values of consumer-orientation and a preventative care focus will continue to remain a strong component of the identity of the new EmblemHealth.

HIP Health Insurance Pioneers Pastoral Care Services

The Beginning of HIP Pastoral Care Services Department

In its effort to improve the quality of service, In July of 1993, HIP established Pastoral Care Services (HPCS) – an initiative unique to its managed care context – in two of the hospitals HIP owned.[16] A serendipitous beginning brought the now 14 year old program to join the ever growing spirituality and medicine movement in America.

Recuperating from a stroke a couple of months after retiring in 1992 as Executive Minister of the American Baptist Churches of Metro New York, the Reverend Carl E. Flemister lamented the fact that the hospital he stayed in did not have a program of spiritual care.

In his illness, Carl Flemister knew that he was endowed with inner strengths and capacities. He enlisted his inner resources through the aid of friends, family, and strangers who ministered to him when he was sick. If you ask him, it was the stranger – a woman with a heavy Irish brogue who daily came into his hospital room to mop the

[15] "GHI History," http://www.ghi.com/default.aspx?Page=8 (accessed February 2008).
[16] Carl E. Flemister, interview by author, September 2003.

floors and give him water – who made a significant impact on his recovery. This woman offered him encouraging words. She reminded him that he was not forgotten; that life mattered and was worth living. This hospital aid, by her concerned and compassionate presence, enabled Carl Flemister to access his determination to get well, rejoin life and find renewed meaning and purpose. In Carl Flemister's own words: "She was a pastoral care person – utterly altruistic and able to meet me on a personal rather than professional level. She was a source of tremendous encouragement." Carl Flemister said that this stranger did many things for him that he did for others as a pastor. Carl Flemister's own doctor urged him to practice what he preached in dealing with his illness.

Carl Flemister, who at the time just became a consultant for HIP, shared this experience with me in February of 1993 while I participated in caring for him at home while he recuperated. Further in our conversation, Carl Flemister expressed his desire to replicate the care he received from the hospital aide for HIP members who are hospitalized. I told him about the Pastoral Care Associate program in Abington Memorial Hospital in Philadelphia, Pennsylvania where I completed a unit of Clinical Pastoral Education (CPE). This program is an auxiliary arm of the CPE program comprised of volunteers who were trained to do hospital visitation. When Carl Flemister got better, I arranged for us to have a meeting with the CPE supervisor, Sr. Angela Fellin, to discuss the possibility of replicating the Pastoral Care Associate program for HIP.

Carl Flemister proposed this program to Anthony L. Watson, Chairman of the Board and President of HIP Health Plan of New York. Watson said: "we can help our members tap their spiritual resources, they may be helped in the healing process." Mr. Watson was persuaded it was something HIP should try in two of the hospitals HIP owed

at the time: La Guardia Memorial Hospital and Syosset Community Hospital now both owned by the North Shore University Medical Center consortium in New York.

HIP Pastoral Care Services Department Hospital Visitation Program

HIP Pastoral Care Services Hospital Visitation Program was established in July of 1993, based upon the belief that that healing is most effective if it cares for all the aspects of the patient including mind, body and spirit and that the best hospital care will be attentive to the spiritual and mental states as well as the physical. A service for the spirit aids in recuperation and assists in prevention. This program was a natural outgrowth of HIP's pledge to persevere as a national health care leader, making HIP the first and only HMO to offer emotional, psycho-social and spiritual support as an added service to its members. This program enabled HIP to tap uncharted avenues to find new and better ways to respond to and participate in the cutting-edge climate of the healthcare field. Because HIP's new business partner GHI has historically shared similar goals and values, it is my hope that what has now come to be known as the Integrative Wellness Department will continue to be a natural expression of the values and ideals of the newly created Emblem Health.

The Hospital Visitation Program is staffed by recruited, trained and supervised volunteers who offer emotional, spiritual and psycho-social support to hospitalized patients, their families and hospital staff. The sensitivity of volunteers is a blessing to a community where compassion and empathy are sometimes lacking. The non-professional nature of volunteerism offers a unique dimension to the healing process. Patients, families and staff need to cope with anxiety, fear, alienation, anger, loneliness as

well as disease. A well rounded complement of care givers provide the treatment needed for the multiple and complex problems of caring for the infirm.

The volunteers historically were referred to as pastoral visitors because of the nature of their work, but pastoral care or pastoral visitation in the context of their work is not the same as it would be in a church setting. The program is non-sectarian in that it does not espouse or promote any religion or teaching other than the maxim that all people are spiritual beings. These volunteers are highly motivated individuals with special preparation to help others tap into and explore spiritual sources of strength. Drawing on spiritual strength or providing pastoral care may include some or all of the following: being a good listener, meditating to gain enlightenment, focusing on sacred or secular texts, praying for the best possible outcome, and connecting with a faith community of one's choice or a support group. The work of these volunteers includes: making appropriate referrals, offering companionship and representing HIP in various communities.

The training courses, clinical experience, supervision and peer groups combine to promote experiential learning. The volunteers develop skills that enable them to deal with and recognize the intricate and complex issues of care-giving and are able to make appropriate referrals and in some instances work in and with the hospitals' interdisciplinary team. The training includes:

- Listening skills - empathic listening
- Privacy regulations - sacred confidence
- Self reflection and self awareness skills
- Self care techniques - care for caregivers
- Issues of grief and loss
- World religious and spiritual practices
- Cultural sensitivities
- Conflict recognition and resolution

- Appropriate prayer - presence and purpose

Volunteer training incorporates clinical experience, role play and evaluation. Supervision is conducted on a regular basis, and requires filling out patient reports, presenting case studies. Volunteers are provided also with continuing education and policies and procedures updates.

Pastoral Care Becomes Integrative Wellness

Pastoral Care Services Expands Beyond Hospital Visitation

In 1997, HIP Foundation Inc. was formed, and Rev. Carl Flemister was named board chairman. At his request, I helped to write the mission statement for the foundation and proposed and implemented six new initiatives, in addition to the HIP Hospital Visitation program. The goal and mission was to ensure well-rounded care to all aspects of the person—body, mind and spirit. Recipients of these various initiatives were HIP members, provider, medical students, employees and the community at large. These initiatives were structured and organized within the newly named Integrative Wellness Department.

I established the first of the six initiatives, *OnCall,* during the latter part of January 1997. *OnCall* was a program that provided emotional and spiritual support to HIP employees while at work. It started as an encouraging phone call to employees who requested it, and ended at the time of Carl Flemister's retirement from HIP in 2004. In April of the same year, I organized *Healthy Living with Chronic Conditions (HLCC)* to offer training and resources to people with chronic illness. *Care for the Caregiver,* as the title suggests, provides programs and resources to caregivers. I created this initiative in June of 1997. I formed the *Medical Facility Visitation Training* to help skilled nursing

facilities and religious organizations develop their own visitation program. This program also was discontinued after Carl Flemister's departure. In 2003, in response to what I saw as a need to equip medical professionals to better serve the spiritual needs of patients, I formed the *Spirituality and Medicine* initiative. This initiative works toward the integration of spirituality in the practice of medicine by offering regular seminars, workshops, and symposia; and is the primary focus of this demonstration project. Another program offered under the auspices of the Integrative Wellness Department since 2006 is the *Cardiac Wellness Program.* This program seeks to improve cardiovascular health and decrease the risk factors for heart disease, with a curriculum including supervised exercise, Hatha Yoga, nutritional counseling, and stress reduction techniques, such as the relaxation response breath work, cognitive therapy, journaling, guided imagery, self talk and prayer.

The work of the Integrative Wellness Department received and continues to receive the recognition of patients, members, affiliate medical facilities, medical practitioners, chaplains, other related organizations and the HIP community. This department supports HIP's pledge to persevere as a national health care leader. HIP is the first and only HMO that offers emotional, psycho-social and spiritual support as an added service to its members. This program enables HIP to tap uncharted avenues to find new and better ways to respond to and participate in the cutting-edge climate of the healthcare field.

The Benefits of Integrative Wellness for HIP

Throughout the years since the inception of the Pastoral Care Services department, and now under the Integrative Wellness Department, HIP has had the benefit of valuable feedback from trained volunteer pastoral visitors who have their fingers on the pulse of our hospitalized members. The message has been that the health care industry has lost the trust and credibility that were once the hallmarks of the medical profession. The public perception, especially in regard to managed care, is that the health care system is impersonal and profit-driven. As Benedict Carey wrote a decade after HIP Pastoral Care Services was launched: "Haggles with insurance providers, conflicting findings from medical studies and news reports of drug makers' covering up product side effects all feed [peoples'] dissatisfaction to the point where many people begin to question not only the health care system but also the science behind it."[17] At the same time, there has been a resurgence of alternative care and re-examination of the relationship between spirituality and healing: "This straying from conventional medicine is often rooted in a sense of disappointment, even betrayal…Many patients see conventional medicine's inadequacies up close – a misdiagnosis, an intolerable drug, failed surgery, even a dismissive doctor – many find the experience profoundly disillusioning, or at least eye-opening."[18]

Historically, religion and medicine were once intrinsically bound together then placed asunder. Now they are being brought back together as a reaction to the volatile, controversial state of flux of our country's health care industry. HIP also wants to

[17] Benedict Carey, "When Trust in Doctors Erodes, Other Treatments Fill the Void," *New York Times,* 3 February 2006.
[18] Ibid.

provide the highest quality medical care and setting national standards for excellence. Through this pioneering program, HIP becomes the bonding agent between spirituality and medicine even as it strives to be the agent for change. The program also has the unique opportunity to counter the negative perceptions of the public by putting a humane face on the health care delivery system. The plan can show that it is concerned about the whole member. HIP also has the chance to deliver health care that is broader and more inclusive than the traditional plans. Rather than narrowing or constricting options, which is the contemporary trend, the HIP Plan can offer a wider range of therapies and treatments that recognizes the various aspects of a member's health.

By adding this program to its list of benefits, HIP supports the needs of community-based organizations. As a volunteer program, HIP Pastoral Care Services can also augment the programs of religious institutions, hospitals and other civic and volunteer organizations, thereby fulfilling its social responsibility. HIP Pastoral Care Services, stands as a valuable adjunct to customary medical care, operating from a holistic model, incorporating diverse disciplines, and developing new programs. Nothing could be more cost-effective than enhancing medical care (and incidentally, HIP's image) through the effective intercession of this service.

Overcoming Obstacles

Creating a Foothold for Spiritual Care in a HMO

Carl Flemister invited me to establish a spiritual care program for the members of HIP who are undergoing hospitalization with hardly any notion or inkling of the complexities this particularly unique setting presented. HIP as an institution is subject to

several city and state, as well as multiple regulatory entities. It must follow guidelines and procedures related to the Health Insurance Portability and Accountability Act (HIPAA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Internal Review Board (IRB). Establishing a spiritual care program within a health maintenance organization required full understanding of the organization's life, mission and intricate structural/organizational makeup in order to best facilitate and deliver the program to its membership. Layers of legal, political and economic issues encompass this intricate and complex systems that make up a healthcare organization. The infrastructure of a healthcare organization, in particular, differs from that of a church setting in the way that pastor/parishioner and HMO/providers relate with each other. I, as an employee of a HMO, did not hold the same status, privileges or authority as a pastor of a church, and this was one of the primary challenges I faced in setting up my doctor of ministry demonstration project.

Despite the significant inroads through the successful programs and initiatives established by the department it still drew a kind of reserved curiosity and ambivalence within the organization and was regarded with criticism and deemed as a threat by other clergy, chaplains, pastoral care department heads and other quasi organizations. Even though the programs were gaining accolades from receptive recipients and beneficiaries the struggle to establish validity within these aforementioned groups remained. Through the course of time, the work of the department, along with the unrelenting healthcare crisis and the decline of peoples' trust and confidence in the healthcare system, the impersonal treatment and shortage of staff to name a few has opened the door a bit wider to complementary, alternative, palliative and spiritual care.

The need to raise the awareness about the program, its validity, legitimacy and overall benefit not only to its target constituency but to the organization, internally and externally, was the overarching challenge. For about five years after the inception of the program, a large amount of time and energy was spent on education, interpretation and definition of the program to a variety of audiences who are resistant, unaware, defensive and altogether puzzled by the whole concept not to mention the lack of definition of the two terms being introduced in a secular setting. Today, the HIP Hospital Visitation Program has carved its place as the flag ship program of the Integrative Wellness Department.

Transition and Transformation of the Integrative Wellness Department

In January 2004, Carl Flemister announced his retirement. In the latter part of 2003, prior to this development, we spent many hours contemplating the future of the department. At the time, I just finished my course work in seminary and was getting ready to implement my project. Knowing the hurdles and challenges we had gone through to that point, it was clear that on top of the challenges we have had to face and are still facing, more and different challenges awaited the department, not to mention the implications of Carl Flemister's leaving on my project.

John White was brought on board to take Carl Flemister's place a few months before his eventual retirement as Managing Director and at a time where HIP's efforts to become a for-profit entity was heating up. Mr. White, a Roman Catholic priest by vocation who worked for HIP's Government Relations division prior to assuming the post with the Integrative Wellness Department, had been briefed and had some

knowledge of the overall internal attitude of some HIP people towards the department. His concern was that others did not think the work of integrative wellness was scientifically based an therefore inappropriate in a medical setting. The need to change the internal perception about the department with the hopes for validity, acceptability and, therefore, accessibility became Mr. White's emphasis.

Language became one of the biggest issues I had to deal with in support of this move. The word "ministry" became service, "pastoral care" was referred to as "spiritual care" to "friendly visitation "compassionate care" to "personalized care" or "member service;" "religion" became "belief/faith system." Even to this day, the word spirituality has to only be inferred behind more benign terms as: mind/body approaches, wellness or preventive health. Because of this, HIP Pastoral Care Services was renamed Hospital Visitation Program.

These philosophical, pragmatic, "marketing" and political issues became the teeth of the fine-tooth-comb that ran through every facet of the department's infrastructure and definition. All promotional materials were re-worked, re-designed, re-worded. No more pictures of doves or clouds, sun bursts, praying hands, etc. The logo of two people – one helping another was eradicated. Any nuance that reflected religion, religiosity or spirituality was scrutinized. The Hospital Visitation Program's mission to provide emotional and spiritual support to hospitalized HIP members is now defined as a "friendly" visitation program where volunteers are also asked to distribute promotional materials for the company. In the midst of this paradigm shift the challenge to integrate spirituality in the practice of medicine through an interdisciplinary approach within a healthcare setting became an even more delicate and complicated endeavor.

The Focus of the Project: Training Medical Caregivers

The creation of the Integrative Wellness Department, borne out of Carl Flemister's personal experience, was a bold and unprecedented move to develop a program that serves HIP members in the way he had been served. In so doing, the necessity to equip and enable caregivers to meet the spiritual needs of their patients came to the fore. This was accomplished by the Hospital Visitation Program with the use of volunteers. The focus of this demonstration project has been to take this mission to equip caregivers to another level by training medical professionals to be sensitive and responsive to the religious and spiritual needs of patients.

Understanding Spirituality in Comparison to Religion

Spirituality is an illusive term and means different things to different people. The term spirituality is also loosely equated with religion and I must insist on looking at these two words separately:

Spirituality is, indeed, indefinable. For who can fully articulate a feeling, sense, or essence of anything – or for that matter, one's threshold of pain? As in truth, it is subjective. Spirituality is one human component that makes an individual unique – as unique as one's own DNA. Here lies another of the challenges of this project: finding an acceptable and effective way of introducing or re-introducing the intangible concept or spirituality within the very rational, tangible scientific medical realm where training, conditioning and, therefore, attitudes of medical practitioners may be institutionally and

theoretically opposed. According to Cobb, Dyson and Forman in the paper they authored entitled: *The Meaning of Spirituality: A Literature Review,* integrating spirituality in the practice of medicine is partly "hindered by the lack of an agreed definition of spirituality and the absence of a conceptual or theoretical framework in which to deliver such care."[19] This group merely tried to affirm difficult task in defining spirituality. They offered a conceptual framework in viewing spirituality but as in any other attempts, it is still contextual, subjective, and therefore, incomplete. *For me, spirituality is that which inspires people to hope in the midst of suffering, doubt and fear; the inherent capacity to aspire for higher things greater than self that gives life meaning; a sentient part that enhances the fundamental virtues, values and character of a person. This definition includes all that a person believes to be ethical – be it founded religiously or otherwise - that influences, inspires, and drives the person's behavior, outlook, and attitude in relation to self, others and the world.*

According to The Reverend Nancy Lane, Ph.D., "spirituality is about the deep search to find personal meaning in life. When one develops [a] spirituality it becomes possible to relate to reality with hope, even in the presence of suffering."[20] *This project assumes the position that spirituality is whatever it means to the individual.* This project will focus on how medical practitioners can be equipped to acknowledge, respect and honor this fundamental, irrefragable, human characteristic.

Equating religion with spirituality posits several issues. Because spirituality is hard to define, most people tend to confuse this term with religion and religiosity. In

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[19] Mark Cobb and others, "The Meaning of Spirituality: A Literature Review," *Journal of Advanced Nursing* 26, (December 1997): 1183-88.
[20] Nancy Lane, Ph.D., http://www.ahealingministry.com/workshops-6.html (accessed April 2004).

general terms, religion is an organized system of belief where adherents are bound by its polity and established principles. In my encounters with patients in the hospital during my chaplaincy training, I found that the phrase: "I'm not religious, but I do believe in God and I try to be a good person" is often expressed, reflecting the difficulty of understanding the difference between these two terms. Cobb, Dyson and Forman aver that "it should not be assumed that spirituality is either synonymous, or coterminous, with religion, and it is suggested that to adopt this restrictive view is unhelpful in the provision of individualized care."[21] Cobb, Dyson and Forman go on to say that the Judeo-Christian tradition of the western society cannot realistically separate religion and spirituality altogether.[22] Spirituality does play a role in the expression and application of religious beliefs but to view spirituality solely within the definition/s of religion is limiting.

Integrating Spirituality into the Practice of Medicine

The work of defining, interpreting and communicating the philosophy and rationale of reintegrating spirituality/belief in medicine continues to pose a challenge in the way the department introduces and weaves programs that includes spirituality in healing and the practice of medicine. The path to integrating a spiritual component to the delivery of healthcare through and insurance company was unprecedented. There was no completely comparable model to draw from, no infrastructure to base any plans of implementation and the whole idea was incomprehensible to both the institution and its members, to enterprises involved in institutional ministry and other clergy.

[21] Mark Cobb and others, "The Meaning of Spirituality: A Literature Review," *Journal of Advanced Nursing* 26, (December 1997): 1183.
[22] Ibid., 1184.

And so his legacy continued for the medical community arguably contends that surgery and drugs were the ultimate and best way to treat medical infirmities. But today, the "business" has become nearly as important as the "practice" of medicine and, therefore, leaves even less room for spirituality. "If a physician has 7.5 minutes to spend with a patient, it doesn't leave time for helping a patient discover his/her spiritual self and to learn to use that as adjunct therapy."[23]

The separation of science and religion brought about a highly specialized approach to medical care. This chasm separated the inextricable aspects of the human organism: the mind, body and spirit. Because of this separation, medical science has become short-sighted, thus, short-changing the patient. If only one aspect of the individual is attended to, healing can never be complete and the total wellbeing of the person is ignored.

This specialized, one-dimensional approach to healing is endemic in the culture, training and preparation of physicians. One notable neurologist declared: "Our conditioning is different than yours (clergy)."[24] A recent survey of the American Association of Directors of Psychiatric Residency Training found that "while religion was viewed as an issue of significant clinical importance, religious issues were infrequently addressed in training."[25] According to Dr. Rachel Naomi Remen, a nationally recognized author and medical educator who sees the practice of medicine as a spiritual path, "the first-year class (or medical students) enters filled with a sense of privilege and excitement about becoming doctors. Four years later, this excitement has

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[23] Michael D. Dalzell, "Pastoral Service Renews Meaning of Faith in Medicine," *Managed Care*, March 1998: 30B-E.
[24] John Blass M.D., telephone interview by author, 12 September 2003.
[25] R. A. Sansone and others, "The Role of Religion in Psychiatric Education: A National Survey," *Academic Psychiatry,* (March 1990): 34-38.

given way to cynicism and numbness. By graduation, students seem to have learned what they have come to do but forgotten why they have come."[26]

Today many doctors are still resistant to integrate spirituality in their practice. In an interview with one of the top neurologists in New York, Dr. John Blass candidly announces: "I tell my patients that they can believe in whatever they want – be it God, chance, luck or natural law – but these things are outside of my area of concern. All I know is that I treat my patients and I wait to see what happens."[27] Medicine is conceived as a cut-and-dried, empirical science that has very little room for error. Levine and Vanderpool confirm this philosophy succinctly: "Medicine is the art and practice of understanding and treating physical and emotional illness so as to: 1) prolong life, 2) restore health and 3) fend off death."[28] This understanding of medicine leaves no room for the intangible, spiritual and inexplicable complexity and mystery of the human condition. Blass continues on to say that: "All I know is that the nervous system develops in the fetus in two or three months. I don't know anymore than what I know. I have no use for people who think they have all the answers either."[29]

This resistant culture might stem from the fact that most doctors are not intentionally trained or equipped to address the spiritual concerns of their patients and as a result, patients are not receiving well-rounded, holistic care. Multiple layers of

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[26] Rachel Naomi Remen, "Recapturing the Soul of Medicine: Physicians need to reclaim meaning in their working lives," http://speakingoffaith.publicradio.org/programs/listeninggenerously/remenarticle.shtml (accessed February 2008).
[27] John Blass M.D., telephone interview by author, 12 September 2003.
[28] Levin and Vanderpool, "Religion and Medicine: How are They Related?" *Journal of Religion and Health* 29, no. 1 (March 1990): 20.
[29] John Blass M.D., telephone interview by author, 12 September 2003.

bureaucratic, economic, and political issues permeate the move to integrate spirituality in the practice of medicine.

At one of the Integrative Wellness Department committee meetings, a medical director declared what I deemed to be a loaded statement: "We understand that our patients' spiritual beliefs play an important role in their healing. But we don't have the time or the know-how to address this issue. You're the spiritual experts. Show us how we can best do this. Give us the tools and we'll be glad to do it."[30] This was the impetus, the bugle call, towards the urgent, daunting and enormous task of finding effective ways of equipping HIP medical practitioners integrate spirituality in their medical practice. This presents a formidable task of affecting this group's scientific orientation with spiritual sensibilities.

A patient asked his primary care physician on his first visit: "Are you a Christian?" "Yes, I am." The doctor replied. The doctor taken aback by the patient's uncanny question commented: "I was amazed that it was more important for him (patient) to know whether or not I was a Christian than to know if I was board-certified!"[31]

A couple having made a decision to donate a placenta asked the doctor if it was alright for them to pray over the human tissue, which in their belief was part of the human soul. The doctor did not quite know what to do with request and awkwardly agreed to participate.[32]

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[30] HIP Medical Director, HIP Spirituality and Medicine Initiative Committee Meeting, New York HIP Headquarters, 21 March 2003.
[31] HIP Health Plan of New York Preventive Health Sub-Committee meeting, Deborah White, Chair, January 16, 2003.
[32] Ibid.

A doctor who had to remove life supports on one of his patients was requested by a family member who was at the bedside to say a prayer. The doctor was surprised by the request. He was never asked to pray for the patient before. After a second of hesitation, he said a prayer over the patient and family members but later shared: "I had many sleepless nights after that. As a physician, I was bothered by having to take a life. I felt helpless. Praying for the patient and the family eased some of the burden I felt. I felt I was able to do something."[33]

"Every now and then, I encounter issues regarding my patients' spiritual beliefs and I don't quite know how to deal with it. I'm not religious myself, though I believe this is important to them."[34]

This escalating attention to the intersection of spirituality and medicine is further demonstrated in the growing trend of including spirituality in medical schools' curricula as Dana E. King explains:

> In 1992, only about five of the 126 medical schools in the United States had required elective courses in religion, spirituality and medicine. Today, over sixty such courses exist, including those at major teaching centers such Harvard, Johns Hopkins, Brown, Case-Western, University of Chicago, University of Pennsylvania, Washington University at St. Louis and others.[35]

There is a growing awareness in the medical field that if only a few of the components of the individual are treated, healing will be partial and illness may manifest itself in other parts of the person. If all the aspects of the person are not dealt with, medical efforts will be futile and total wellness will not be achieved. Scientific research

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[33] Ibid.
[34] Ibid.
[35] Dana E. King, *Faith Spirituality and Medicine: Toward the Making of the Healing Practitioner,* (Binghamton, New York: The Haworth Pastoral Press, 2000), ix.

has proven that most ailments are caused or exacerbated by emotional and spiritual factors.

Christina Puchalski, director of the George Washington Institute of Spirituality and Health and Assistant Professor of Medicine at the George Washington University School of Medicine and Health Sciences asserts that "it is difficult for some doctors to initiate this kind of care because there has never been a focus on the background of the patient."[36] In spite of the numerous scientifically based studies on narrowing the gap between spirituality and medicine, there seems to have been no conscious effort to connect these two fields in the practice of medicine, even though statistics show that the number of patients demanding the integration of spirituality in their medical care is rising. In a recent poll of 1000 US adults, 79% of the respondents believed that spiritual faith can help people recover from disease, and 63% believed that physicians should talk to patients about spiritual faith.[37] However, many medical practitioners' lack the necessary tools and resources that can assist them in dealing with the spiritual dimension of their patients.

In spite of the vast empirical research that provides evidence to the crucial and critical role of spirituality in medical care, still many doctors are resistant to integrate spirituality in their practice. Time constraints, lack of knowledge and access to resources, absence of an infrastructure and methodologies, cultural and religious differences, specialized or one-dimensional training and conditioning are but a few obstacles that stand in the way of facilitating the integration of spirituality in the practice of medicine.

[36] Christina Puchalski, www.healthatoz.com/atoz/news/uwire, 2 (accessed April 2004).
[37] Christina Puchalski, www.christianhealth.co/connect/007, 2 (accessed April 2004).

Having heard and identified the need for resources and direction on this matter, and knowing that the role of spirituality in medical care is fraught with controversy and unresolved conflicts – not to mention the public perception that the health care system is impersonal and profit-driven - HIP took the opportunity to counter the negative perceptions of the public by putting a "humane face" on the health care delivery system by welcoming the HIP Integrative Wellness Department. Through this department, the plan could show that it was concerned about the total wellbeing of the member and had the opportunity to demonstrate a care that was broader and more inclusive than the traditional plans. Rather than narrowing or constricting options which is the contemporary trend, the HIP plan could offer a wider range of therapies and treatments that recognized the various aspects of the members' health.

Navigating a Complex and Resistant Corporate Environment

A good amount of study of the HIP system, the role and function of every department was the primary necessity in establishing the infrastructure for the Integrative Wellness Department to function effectively. Knowing and identifying these various departments enabled me to locate appropriate resources and access to promote and establish the program. Human Resources, Ombudsman, Member Services, Provider Relations, External Affairs, Marketing and Communications, Medical Quality Informatics, Medical Management, were a few departments that I had to establish a working relationship with. Staffing became the next issue. Finding people who had theological/pastoral training as well as possessing corporate experience and savvy was difficult. Then there was creating a budget, ensuring compliance with policy and

procedures to establishing relationship with the various affiliated hospitals. Interpreting the program, identifying key people and securing access from within a very dense policy and procedure was an incredible challenge to face.

The concept that religion is synonymous with spirituality has raised another setting specific challenge in my context of ministry. Most of the top executives did not consider themselves religious for various reasons. So when the idea of integrating spirituality in the delivery of medical care was introduced, it brought about a lot of suspicion, opposition and at times, ridicule. It was not enough that there exist voluminous scientific studies that support the role of spirituality in health. As Mehmet Oz, professor of cardiac surgery at Columbia University, stated in a recent interview, if in your heart you believe that (for example) prayer makes a difference in healing, you will find the data sets that support that. And if you believe that prayer does not make a difference, you will find the data to support that. At the end of the day, in our technological scientifically oriented world, the smarter you are, the better you are at finding data that supports your biases, religious, spiritual, or otherwise.[38] The challenges at HIP were dense, multi-layered and complex. Antipathy to religion among my colleagues created an environment that was often hostile in the context of which I presented my project. At times, those decision makers who were ambivalent gave the program lip service; those who were sympathetic and agreeable were noncommittal or silent for fear of being labeled.

[38] Mehmet Oz, "Heart and Soul: The Integrative Medicine of Dr. Mehmet Oz; Unedited Interview," http://speakingoffaith.publicradio.org/programs/heartandsoul/index.shtml (accessed January 2008).

CHAPTER II

The Challenge

It is not a question whether there is a connection between what we believe and our physical health. Rather, it is a question whether there is a way that we can narrow the divide between belief/faith and science so that medical caregivers can also pay attention to the spiritual dimension of the individuals in their care and acknowledge that the spiritual aspect of the individual plays a significant role in their health, healing and overall sense of wellbeing. What are some ways that would generate medical practitioners' interest, cooperation and participation in integrating this human component in their delivery of care? Can these caregivers be equipped to direct their stethoscopes not just to the location of the cardiovascular muscle but to the *heart* of the patient as well?

When faced with a health crisis, people tend to take stock of their lives, and ask profound existential, theological and spiritual questions. Fear, loss of control, vulnerability, mortality, alienation, loneliness, suffering, anxiety, guilt; sadness, despair, isolation are some issues that confront the infirm. These issues are often worse than the illness itself.

Illness throws one in a crucible. Webster's dictionary has defined crucible as "a state of pain or anguish that tests one's resiliency and character."[39] It is in this crucible that the condition of the mind, body and spirit meld, coagulate. It is at the patient's state of pain and spiritual anguish that doctors should join others in the interdisciplinary arena to facilitate the patient's total healing and recovery. If only a few of the components of the individual are treated, healing is partial and illness will re-manifest itself in other parts of the organism. If all the aspects of the person are not dealt with, doctors' efforts will be rendered ineffective and total wellness will not be achieved. Recurrence, and new chronic diseases and syndromes will be the course.

The current highly specialized and therefore, fragmented approach to the delivery of medical care needs transformation to facilitate a fluid and integrated development of an infrastructure and methodologies that will facilitate a more complete treatment of the infirm. As Puchalski pointed out, the import of knowing the patient's overall history or background at the point of service determines the quality and efficacy of the delivery of care.[40] This demonstration project is in response to the aforementioned specialization and fragmentation of the delivery of care which permeates the whole healthcare industry where a different practitioner takes care of the feet another the heart, another the kidneys, another the endocrine glands, etc., etc., and they don't necessarily communicate with each other and the patient is thrown in the limbo of costly medical tests, multiple medications, side effects and chronic conditions.

In response to the fragmentation of the modern healthcare system, this demonstration project's initial challenge was to organize an interdisciplinary team that

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[39] "Crucible," *The American Heritage College Dictionary, 3rd ed*., (Boston: Houghton Mifflin Company, 1993), 297.
[40] Christina Puchalski, www.healthatoz.com/news/uwire (accessed April 2004).

would promote the integration of spirituality in the practice of medicine within HIP. The plan was to accomplish this through training and dialogue with participants. A spiritual assessment tool that would be utilized in medical practice, and introduction to spiritual practices like the "Relaxation Response" of Dr. Herbert Benson would be a part of the agenda of the interdisciplinary team. The team would then disseminate the knowledge and findings derived from this group, engage in continued research, and develop a manual that would serve as a resource for those interested in implementing an approach to medical care that incorporates mind-body-spirit.

Comparable Ministries

The unprecedented nature of the project was in itself a challenge. However, there were several organizations whose mission and function were comparable. These became resources for my project and my work at HIP.

Association for Clinical Pastoral Education

The Association for Clinical Pastoral Education (ACPE) is a program that has some similarities to my project.[41] This organization is composed of directors and several committees. As defined:

> Clinical Pastoral Education is an interfaith professional education for ministry. It brings theological students and ministers of all faiths (pastors, priests, rabbis, imams and others) into supervised encounter with persons in crisis. Out of an intense involvement with persons in need, and the feedback from peers and teachers, students develop new awareness of themselves as persons and of the needs of those to whom they minister. From theological reflection

[41] ACPE headquarters is located at 1549 Clairmont Road, Suite 103, Decatur, Georgia, 30033.

> of specific human situation, they gain a new understanding of ministry. Within the interdisciplinary team process of helping persons, they develop skills in interpersonal and inter-professional relationship. [42]

My project seeks to integrate spirituality in the practice of medicine by providing education and resources to HIP Medical group physicians. The curriculum and resources I am developing, like the CPE program, include spiritual assessments, educational tools, and inventories for use in a multi-faith context.

If doctors can acknowledge their spiritual attributes, they in turn will be sensitive to the spiritual needs of their patients. If this project can also revive a sense of "ministry" or "vocation" for them [doctors], this would be an "added value." The CPE discipline is one that I would like to emulate because it has done a lot toward building interdisciplinary relationships with other medical professionals.

Benson-Henry Institute for Mind Body Medicine

Another comparable ministry or program is the Mind/Body Medical Institute now called the Benson-Henry Institute for Mind Body Medicine (BHI).[43] The organization is composed of a board of directors, administrative officers and clinical staff with affiliate programs in Nashville, Tennessee, Houston, Texas, Richmond, Virginia, Portsmouth, Virginia and Tacoma Washington.

> The Benson Henry Institute is a non-profit scientific and educational organization dedicated to the study of mind/body interactions, including the relaxation response. The institute will use its expertise to enhance the recognition and understanding of mind/body medicine's role in the practice of medicine and to foster and expand the uses of mind/body interactions in healthcare and other appropriate settings, and thereby, to advance health and well-being throughout the world. It accomplishes these objectives in a variety of ways, including:

[42] "What is Clinical Pastoral Education?" www.acpe.edu (accessed February 2008).
[43] The main headquarters is located at 824 Boylston Street, Chestnut Hill, Massachusetts, 02476.

> - Documenting and furthering the understanding of scientific bases of mind/body medicine, including the role of belief, and exploring their uses by conducting basic and clinical research, both independently and collaboratively;
>
> - Disseminating its knowledge and experience and the results of its findings through medical and general publications, lectures, symposia, continuing medical education programs and other appropriate media;
>
> - Quantifying the benefits and costs of mind/body programs;
>
> - Teaching medical students and training post-doctoral fellows and other researchers;
>
> - Training health care professionals, educators and clergy and helping them integrate mind/body interactions into their work, and;
>
> - Fostering the establishment of clinical and research programs in institutions that provide health care.[44]

The Benson-Henry Institute on Mind Body Medicine (BHI) is a comparable program in that it is a similarly organized not-for-profit institution. HIP was able to establish an affiliation with BHI in 2004. The association led to the establishment of HIP's Cardiac Wellness program. When I went with executive staff from HIP to visit the BHI site in September 2003, we found that their goals and objectives are similar to that of HIP Integrative Wellness' Spirituality and Medicine program. Currently, we are looking at other programs, i.e., childhood obesity, fertility programs, etc. to adopt and include in the Integrative Wellness Department's list of programs.

[44] Herbert Benson M.D., "The Affiliate Program of the Mind/Body Medical Institute," Brochure, 2003: 6.

George Washington Institute for Spirituality and Health

The George Washington Institute for Spirituality and Health, a university-based organization founded and directed by Christina M Puchalski, MD, has as it's goal "restoring the heart and humanity of medicine through research, education, and policy work focused on bringing increased attention to the spiritual needs of patients, families, and healthcare professionals."[4546] The institute offers programs for doctors and other members of the interdisciplinary healthcare team, including chaplains and clergy; and has created a significant impact on medical care and education locally, nationally and internationally.[47]

Several other comparable programs came to the fore in the course of this project. All of these programs or organizations have been affiliated with HIP Integrative Wellness Department (IWD) either through referral or contracted to resource the IWD annual symposium. These programs and institutions may be compared with the project in terms of their focus on spirituality and health and integrating spirituality in the practice of medicine. These organizations, their founders and a description of their work and relationship to this project are described in chapter IV:

- The Tanenbaum Center for Interreligious Understanding
- Andrew Weil, M.D.
- Mehmet C. Oz, M.D.
- Harold G. Koenig, M.D.

[45] "The George Washington Institute for Spirituality and Health," http://www.gwish.org (accessed February 2008).
[46] It is located at The George Washington University Warwick Building, Suite 313 2300 K Street NW Washington, DC 20037.
[47] Ibid.

While none of them provided a template or guide for the Demonstration Project, these comparable ministries have become points of reference, sources of information, studies and research.

CHAPTER III

Site Team Response

The site team was chosen to represent various roles and functions I deemed necessary to support the project, from clerical, statistical, research support to political, spiritual and pastoral care.

Members of the team were strategically chosen not only because I thought that they understood and supported my work at HIP but also to reflect the diversity and interdisciplinary nature of the project. Twelve people from very diverse backgrounds - covering a vast gamut of race, gender, religion, age, level of education and profession were picked. They are friends, colleagues and partners in ministry – people who are familiar and intimately privy to my vocational goals, aspirations, hopes and dreams. The site team members are:

Reverend Carl E. Flemister	Senior Vice President, HIP Integrative Wellness (Retired)
John White	Managing Director, HIP Integrative Wellness
Deborah White, M.D.	Medical Director, HIP Quality Management
Reverend Aundreia Alexander	American Baptist Churches National Ministries
Reverend Martha Cruz-Jenks	Director of Communications, United Church of Christ
Reverend Felicia Thomas	Senior Pastor, First Baptist Church, Princeton, NJ
Grace Griffenberg, Ph.D.	Consultant, Board Member HIP Health Plan of NY

Hedda Matza-Haughton, LCSW	CEO and President, For the Health of It
Eunice Salton, Ph.D.	CEO Plays for Living
Beatriz Jaramillo, Ph.D.	Director, HIP Medical and Quality Informatics, Health Services Analysis Unit
Reverend Richard Burke	Manager, HIP Hospital Visitation Program
Reverend Ann Kansfield	Manager, HIP Healthy Living with Chronic Conditions
Reverend Gregory Johnson	Assistant Director, HIP Care for the Caregiver

The team responded enthusiastically to the challenge of this project, expressing support and encouragement. Carl Flemister was chosen to chair the team and we held a monthly meeting at the HIP Headquarters, then located at 7 West 34th Street. I brought them to the NYTS meetings and invited my advisor, Lester Ruiz to attend several meetings. To members of the clergy in the team, there was no question as to the "how "or "why" with regards to the D.Min. program and the project. Those who were not clergy raised some concerns with regard to the project's relationship with HIP as an organization and the HIP system; how the project would be implemented and how their involvement in my D.Min. work might reflect on them as HIP employees. For awhile, the team continued to meet after hours and for me, it felt like a covert/subversive group within HIP and I would not be surprised if some of them felt the same way. I'm not sure exactly how this dynamic worked out but one thing was obvious to me: their earnest commitment to support me in my work, giving me their trust and confidence that I would find a way to appropriately integrate the work of the project with the goals and mission of HIP. The team's apprehensions may have been alleviated by the fact that Reverend Flemister, a Senior Vice President at HIP, acted as chair of the team, supported my

education and endorsed my project. The response of the Site Team to the initial Challenge Statement, namely, *to organize an interdisciplinary team that will promote the integration of spirituality in the practice of medicine within HIP,* was highly supportive, regarding the project as crucial and critical to the work of Integrative Wellness. The non-clergy members of the team were intrigued by the initial Challenge Statement. They were curious about the whole idea of incorporating spirituality in medical practice, intrigued about how their contemporaries would respond to the invitation to be a part of the interdisciplinary team, and wondered about how this would be implemented in the HIP system given its complex infrastructure and bureaucracy. The clergy members felt that the challenge was long overdue and saw that conversely, physical health was an area in ministry that needed to be made a part of the church's mission toward wholeness. Both of these groups did agree that the challenge was a daunting, ambitious endeavor.

The team remained intact for about two years, from 2001-2003. In 2003 I lost my administrative assistant, who was a huge support to me; she was not replaced. In January 2004 Carl Flemister announced his retirement. In July of that year, HIP moved its headquarters from 34th Street to Ground Zero. Organizational changes took place thereafter, with the employment of John White as the new head of Integrative Wellness Department. Site Team members from HIP retired, resigned, and were dismissed from there jobs. Others changed jobs, moved out of state, fell ill and excused themselves due to work-related reasons or family crises. After the two year mark, the meetings started to become difficult to arrange. Instead of meeting monthly, we met quarterly. Attendance began to dwindle sometimes only having half of the membership present. Meetings via tele-conference were held but it became harder to get everyone on the same schedule.

Gradually the team disbanded as an official group in the sense that we no longer meet on a regular basis and I have lost contact with some of them, but some members of the team continued to keep in touch to this day.

At the end of 2004, I met with my advisor to discuss these developments and evaluate how the changes that took place impacted on my challenge statement. The loss of Carl Flemister, in particular, made the assembly of an interdisciplinary team for the purposes initially envisioned for the project impossibility. The meeting resulted in the amendment of the challenge statement: *to develop an educational program that will promote the integration of spirituality in the practice of medicine within HIP.* Contacting as many team members as I could to inform them of the modification of the challenge statement, I received a much relieved, highly positive response. It made more sense given the organizational change, it no longer seemed impossible to accomplish and did not require hedging through a dense bureaucratic jungle. Members of the team who remained at HIP and those in the tri-state area continued to lend support individually through their phone calls, visits, encouragement, prayers and well-wishes, reminding me to do "self-care," including sending related articles, internet links, statistical reports, etc. The initial group was a blessing and continues to be as such. I am also grateful to the people that I added to the team to help me:

Mary Jo Johnson, M.Div.	Licensed Acupuncturist and Integrative Medicine Practitioner
Joyce Co Tsang	HIP Manager, Medical Informatics
Caterina Mako	HIP Manager, Hospital Visitation Program
Diana Cooper, R.N.	HIP Assistant Director, Healthy Living With Chronic Conditions
Nikolaos Vartholomeos, D.P.T.	Integrative Medicine, Allied Health Practitioner

Margaret Pape Speech therapist, School Teacher

These amazing individuals have offered to be readers and scribes, researchers and spiritual partners, editors and consultants. They are proponents, practitioners, students and teachers of spirituality and health. Their passion for this work fuels mine and is a source of inspiration that was very much needed to complete this project.

CHAPTER IV

Ministerial Competencies

As noted previously, healthcare is a hot topic. All around us are victims of the healthcare system. Millions of Americans, many children, are not covered by insurance because of cost. Prescription prices force the elderly into poverty and workers are paying more and more for their coverage. The quality of medicine is suspect, especially for those of little means. Many have spent all they have on doctors and medicine, to no avail. Every family has personal stories of malpractice, gross negligence, inadequate and impersonal care.

The increasing malpractice insurance rates that brought New Jersey doctors to stage a strike is indicative of a system in crisis. This has significantly affected the doctor/patient relationship. Trust has been replaced with suspicion. In one episode of 60 Minutes, one of the doctors who was interviewed lamented the sad fact that other than HMO's "patients are the enemy."[48]

Sophisticated technology is now making people live longer while the healthcare system remains in a state of flux and the economy is volatile. Events of 9-11 and the wars that ensued have increased peoples' sense of vulnerability. Given these obstacles physicians have to face, do I really think that they have the time or the interest to present additional work to their already busy schedules? This is a worthy challenge that I am

[48] Jennifer Warner, "What Patients Want," *CBS News 60 Minutes*, 11 March 2003.

willing to make if it will improve doctor/patient relationship, improve the quality of care ad the overall health and wellbeing of patients.

In conversation with a professor about this project, he raised these questions: "How will you be helping God help these medical practitioners?" "What is God doing in the world that signifies that there is a need to pay attention to the role of spirituality in medicine today?" "How do [I] envision the transformation of medical practitioners and the medical world and how might this transformation impact on their lives and the lives of their patients?"[49] These questions help raise and identify obstacles, and resources, my competencies and limitations, that are critical to the development of this project.

The call to be an active participant in the healing community of God requires from me an honest, assessment and affirmation of my God-given gifts and capabilities as well as my limitations and needs in order for me to keep the integrity of the project set before me. Affirming this Calling will grant me the spiritual strength, passion, inspiration, fortitude, authority that I will need to see the project through.

I was raised with a legacy of faith that bears witness to the notion of God's love and power and does not preclude the miraculous. As I have witnessed the lives and deaths of my extended family, questions of spirituality and health have been intertwined and as such have fueled my interest, passion, work, and now, my project.

My diverse context, multi-cultural, inter-faith background has taught me to appreciate well-rounded, global, interdisciplinary, egalitarian modes of operation and perspectives. It has afforded me a sensibility and sensitivity that is able to work within a complex power structure and dense bureaucracy. I also come from a culture that puts value and importance on corporate identity. Everyone shares the glory of success and

[49] Lester Ruiz, conversation with author, March 2003.

everyone is accountable for failure. We celebrate together and we grieve together and always supporting each other.

I tackle this project under the guiding principle that the success of any undertaking is based solely upon how one is able to acknowledge that we are interdependent; that the interdisciplinary approach, where each and every member, with their unique gifts, expertise and qualifications is integral to the healing community – as vital as a body-part or an internal organ. The interdisciplinary approach simply presupposes that each part - the body, mind and spirit – must work together if complete healing is to be achieved.

Clinical Pastoral Education has enabled me to detect or discern spiritual roots of some maladies. The severity, if not the onset of many illnesses can be traced to the spirit. The Chaplaincy helped me to broaden my understanding of health and wellness to include the spiritual and emotional and psychological aspects. I utilized and increased my cross cultural and inter-religious sensitivities during my academic preparation at Harvard Divinity School, the teacher training and curriculum development with The Pacific Asian-American Christian Education, USA, and involvement with organizations like the Interfaith Peer Action Group, USA, American Volunteer Administration, Quota Club International, etc. The skills I gained in working with diverse groups of people in various settings were invaluable in furthering the goals of this project.

In my previous experience in working with other corporations, religious organizations and having owned and run several private businesses of my own, I utilized the ability to build and understand organizational systems and structures. The competencies gained from these experiences enabled me to identify and access potential resources, assess needs, design appropriate programs, erect infrastructures, supervise and

direct people, find solutions to problems and manage large budgets at HIP (see Appendix D Professional Experience).

In my work with HIP Integrative Wellness, I have summoned and developed new skills to create and establish an unprecedented program within a most unlikely setting from the ground up (see Appendix A, Integrative Wellness Departmental Brochure). From naming the department to establishing several other programs within the department to interpreting its mission and goals both internally and externally to building infrastructure, e.g. creating a recruitment and screening process; to developing curriculum, hiring faculty; from devising forms to fashioning a reporting and monitoring system; from developing policy and procedure to ensuring legal compliance; from staffing to budget development to supervision to administration, etc., etc.

This unique undertaking and experience made me appreciate protocol more than hierarchy; diplomacy more than bureaucracy; "soft" management style more than pulling-rank; collaboration more than politics. Though I've been told too often that I was "too nice," I found that these sensibilities have, without a doubt, facilitated a collegial spirit within and among people with whom I engaged in this project. It provided easy access and resources needed to accomplish the task. When I proposed to Carl Flemister that I was considering enrolling in the New York Theological Seminary Doctor of Ministry program, he was very supportive and helped arrange tuition reimbursement. He also told me that he needed to let Anthony Watson know that I was going for the D.Min. program and that he too was supportive. Having these two executives sponsoring and validating my work opened doors and made it much easier initially to accomplish my goals. But even with this support, I was cautioned to keep the Integrative Wellness

program apart from the project. Though the project was for the betterment of HIP, ultimately, the degree was mine. This made me feel somewhat uncomfortable as times to ask for what I needed. Expecting things from people because it is in their job description is different from expecting them to do things for me so I can get my degree.

This dilemma runs throughout the course of this project primarily because the program is not officially endorsed by HIP. It did not take long for me to realize that I did not hold any power to impose. I only had the ability to insinuate, suggest, recommend, persuade…within the limitations impressed by my position at HIP. These skills became even more important when Carl Flemister retired. I had to navigate the whole system without Carl Flemister's clout, connections and facilitation. He was my primary connection to the medical directors and the only person who supported my going back to school and understood the connection and import of the D.Min. program to our work. This was compounded by the fact that the department no longer belonged to the Foundation and therefore lost its legitimate place and its autonomous identity. I now had to fight with competing medical interests for funding. I had to establish my own relationship with key people (introduce myself to newly hired people, interpret and orient them to the mission of the department) and reworked my project within the philosophical and structural changes after Carl Flemister's retirement. This required time spent on strategizing and developing networks within HIP, which required more than a couple of years to work out. What I found is not so much as physicians' resistance to the idea of spirituality as it is political, organizational and structural issues. HIP's medical division wherein the Integrative Wellness Department is housed had undergone several leadership changes, at least three in the past four years. Each time, we had to educate the incumbent

about the role and function of the Integrative Wellness Department; each time some of the essence of its spiritual characteristic was lost and changed to health promotion and disease prevention, mind-body, self-care, behavior modification – terminologies that I could no longer understand and connect with the principle from which we first established the department.

As my direct supervisor, Flemister's support of the program was critical to the project. His position, influence and endorsement held the key to facilitate the project's plan of implementation. The organizational chart indicates this reliance on Flemister's support (see Appendix B, HIP Organizational Chart).

My assistant and other support staff in my department offered clerical and technical support setting up Site Team meetings: reserving conference rooms, informing and reminding Site Team members of the meeting, arranging catering, copying agenda and other materials. This did take staff time and HIP resources and I needed to make sure that it did not get in the way of doing their HIP work.

Co-workers and friends from other departments within HIP gave invaluable resources needed for this project, i.e. devising statistical data, measuring tools, surveys, assisting in conducting interviews, researching information, etc. Getting their input was predicated upon articulating the purpose and goals of the project in such a way that it was consonant with their own job responsibilities in particular and the mission or HIP as a whole. *I was successful in achieving the goals of the project because I was able to translate and interpret the goals of the project within the goals and mission of HIP.* Although getting and maintaining the support for Integrative Wellness is an ongoing challenge internally, our work does give HIP a more attractive public image, particularly

in these times when so many people are looking for complementary and patient-centered services. In fact, looking at HIP's website shows how HIP has embraced the work of the Integrative Wellness Department in terms of its public face. Integrative Wellness is literally front and center on the home page of their website.[50]

Professors, Site Team members and classmates provided an incredible amount of support – from their knowledge and experience to spiritual and moral sustenance. The Site Team members included CEO's of organizations like Plays for Living and For the Health of It, officers and directors of HIP, a seminarian, physician, ombudsman, priest, actor/musician, denominational executives representing various protestant denominations, Roman Catholic and Jewish. The depth and breadth of insights, knowledge, expertise and wealth of resources this team brought to my project enriched, added texture and perspective to my project.

The Competencies Process

The competencies process I underwent with the Site Team brought to the fore the "disconnect" between the program and my ministerial setting. The ministerial competency evaluation was viewed by the Site Team to be inappropriate. Those members of the Site Team who were not clergy did not feel they were qualified to evaluate me under the categories of the evaluation instrument. Some recused themselves from participating in the process. Others who did participate skipped areas when they felt they could not respond. The category *Preacher* was omitted. Some members had to

[50] "Welcome to HIP USA.com," http://www.hipusa.com (accessed February 2008).

be “educated” to the whole concept of the “Demonstration Project” as opposed to a Thesis or Dissertation in addition to the difference between a Ph.D. and a D.Min. degree.

The competencies in the assessment tool asked for the following categories:

1. Theologian
2. Preacher
3. Worship Leader
4. Change Agent
5. Ecumenist
6. Leader
7. Religious Educator
8. Counselor
9. Pastor/Shepherd
10. Spiritual Leader
11. Administrator
12. Professional Skills

The summary of the Assessment of Candidate Competency was prepared by a Site Team Member, Beatriz Jaramillo, Managing Director, HIP Medical and Quality Informatics:

Methodology:

- Qualification words were assigned numerical values: **Continue = 4, Develop = 3, Attention = 2, Start = 1.**
- Total Average is calculated by the total values for each capacity divided by number of people reporting the particular capacity.
- Overall total average is calculated by the total number of reported numerical values for all capacities within a category divided by the number of reported values within each category.
- No entries were entered for the preacher category due to no basis for assessing candidate in that area.

The following Site Team members (STM) provided their evaluations:

STM1 – Grace Griffenberg
STM2 – Richard Burke
STM3 – Carl Flemister
STM4 – John White
STM5 – Deborah White

STM6 – Aundreia Alexander
STM7 – Beatriz Jaramillo

The average evaluation scores are as follows:

Theologian – 3.8
Worship Leader – 4.0
Change Agent – 3.8
Ecumenist – 4.0
Leader – 3.9
Religious Educator – 3.9
Counselor – 3.9
Pastor/Shepherd – 4.0
Spiritual Leader – 4.0
Administrator – 3.9
Professional Skills – 3.7

(see also Appendix J, Summary of Assessment of Candidate Competency)

Upon receiving the results of the evaluation, I developed goals and objectives based upon the outcome and recommendation of the Site Team. The Site Team expressed their concern for my health and well-being and suggested that I work on the Professional Skills and Spiritual Leader categories. We agreed that these goals also applied to the amended Challenge Statement.

The Professional Skills Goal

My professional skills goal is to better manage my time and set boundaries, limiting my work-load to what is do-able and to be able to say "no" when that is warranted. In order to fulfill this goal, I decided to devote Mondays to writing and research. I was also able to get approval to work from home two Fridays a month. This allowed me to catch up on readings that would help me achieve this goal. These books were:

Cranston, Pamela Lee with The Clergy Wellness Commission, Episcopal Diocese of California. *Clergy Wellness and Mutual Ministry: A Resource for Clergy and Congregations.* Oakland, CA: O'Brien and Whitaker, 2000.

McGee-Cooper, Ann with Duane Trammell. *Time Management for Unmanageable People.* New York: Bantam Books, 1994.

Maxwell, John C. *The 21 Irrefragable Laws of Leadership: Follow Them and People Will Follow You.* Nashville Tennessee: Thomas Nelson, 1998.

In addition, I had planned to delegate appropriate responsibilities to members of the site team and take the whole month off in the latter part of 2004 to finish the project by February 1, 2005. This, of course, did not happen due to the retirement of Carl Flemister and other circumstances mentioned in previous chapters.

After reviewing my job responsibilities and assessing the status of current projects I was working on, a work plan that would accommodate the completion of this goal as well as my responsibilities at work was presented to my supervisor. When Carl Flemister left, I continued to follow the work-plan and made adjustments appropriate to the changes that ensued including the change in the Challenge Statement.

The Goal to Improve Competence as a Spiritual Leader

This goal called for the observance of "Sabbath time," meaning making time for a regular day off and periodic days apart or retreats for spiritual refreshment. I took part in "Together in Ministry," a meeting of ministerial colleagues sponsored by the American Baptist Churches USA Ministers' Council. The focus of "Together in Ministry" is to create a supportive community of ministers that enriches their perspectives of themselves as leaders in their communities and provides a supportive network of peers who pray for

one another and create a climate of mutual accountability.[51] I took yoga classes, enrolled in Herbert Benson's "Relaxation Response" classes, and set aside time to paint.

I planned to take my learnings from Together in Ministry and the other spiritual practices and to impart them to the Interdisciplinary Team, but because the team was not formed, this plan did not materialize. The evaluation process that was planned for this goal was for me to keep a journal, recording the Interdisciplinary Team's feedback on their experience of the spiritual practices that I had planned to present to them (breathing exercises, meditation, guided imagery, etc.). In addition to evaluating this process, I wanted to create a spiritual assessment tool or questionnaire that would measure the level of consciousness reached, need, attitudes, issues/concerns, skills, etc.

The HIP Medical Providers and other doctors were the principal focus group of this project as much as they were a resource. Their participation was and remains integral to the project. In the end, as I consulted with the Health Status Improvement Subcommittee (HSISC) in lieu of the Interdisciplinary Team that I had originally planned, the medical providers themselves were the ones who continued to provide the necessary information to validate and help shape the direction of the project. At the meetings of the HSISC, utilizing time before and after the agenda items were reviewed, and when I met them in various other settings, I assessed physicians' attitudes, thoughts, and concerns regarding the relationship of spirituality and medicine and how spirituality could be integrated into their practices. Despite their lack of time, past or present negative experiences with religion, and/or constant pressures to provide better service in the face of dwindling resources, I managed to make a meaningful connection with them and discover ways to provide the spiritual resources that they were requesting.

[51] "The Ministers' Council," www.ministerscouncil.com/TogetherInMinistry (accessed February 2008).

The seeming obstacle of the sudden lack of institutional support for the Spirituality and Medicine program in its original form required me to proceed with delicacy, diplomacy, sensitivity, respect and genuine care and concern for my medical constituency. The surveys and studies mentioned in preceding chapters proved that although HIP as an institution could not endorse . (see Appendix C, Summary of Symposium Evaluation).

The Medical Group Staff (physician's assistants, receptionists, nurses) are the front line crew at the point of service. They are key participants in the implementation and utilization of some aspects of the project, i.e. taking patient spiritual inventory, making referrals, etc. But the cost-cutting has decreased personnel and the amount of paper work demanded by HMO's escalates. This group may not have the time to take on added responsibilities. Because the project never got to the medical groups, and given the barriers that stood in the way of implementing the original strategies, an alternative process had to be created.

The development of a spiritual educational program for medical providers required competencies that were derived from the skills and work experience I had in the past (see Appendix D, Professional Experience). Most important were the self-knowledge and experiential learning of spiritual care for individuals and communities that remain at the heart of this project. My CPE experience in particular honed these competencies. I also utilized conflict management and program and curriculum development skills, and the interpersonal skills gained from years of working in a church setting with its thick history, complex processes, infrastructure and political bureaucracies.

My growing edges throughout this experience included the need for flexibility in dealing with unexpected situations. I also needed endurance and determination to continue approach people to talk about the value and significance of spirituality in the medical setting. Having to work with very little institutional support, I learned to depend on myself. This situation continually challenged me in the area of self-care as I pulled together the resources and energy to continue this project and the work of connecting spirituality and medicine.

CHAPTER V

The Story Retold: Transformative Steps

Initially, I planned to achieve five goals as part of the project. The goals were as follows: 1. Organize an Interdisciplinary Team (IT) that will work towards the integration of spirituality in the practice of medicine; 2. To enable and equip medical practitioners in one of HIP's medical groups integrate spirituality in their practice; 3. To document and disseminate the knowledge and findings of the IT; 4. To the further research on the impact of the training of HIP medical group practitioners on spirituality and medical practice and utilization of the spiritual assessment tool; 5. To develop a new paradigm for the integration of spirituality and medicine. Due to the major shift in priorities of the administration of HIP as a result of the departure of Carl Flemister, these goals had to be revised and reinterpreted in order for the project to continue. In this chapter, I describe each goal, the changes that had to be made, and the transformation that occurred as a result of these changes.

Organize an Interdisciplinary Team (IT) that will work towards the integration of spirituality in the practice of medicine

Originally the project called for the establishment of an IT that was to be composed of 20 individuals: physicians from various specialties, clergy, nurses, medical researchers and key officers of HIP New York. Their main task was to engage and

participate in various pedagogical methodologies that would examine their own attitudes, concerns and issues around spirituality and find means to disseminate their findings to their colleagues and develop practical tools for medical practitioners to test and utilize in one of HIP's medical groups. The educational modules that would be offered at the IT monthly meetings were to include: examining and testing various spiritual assessment tools that I would furnish; seminars and workshops that would be facilitated by experts in the field, round-table discussions around peer-reviewed studies and publications including presentations by chaplains from various religious traditions.

The goals for the IT were to enhance their knowledge and awareness about the role and function of spirituality in healing; to recognize how spirituality impacts on the biological, emotional and psycho-social dimensions of their patients and to be able make an informed spiritual diagnosis. In addition, the IT would be able to gain a deeper understanding of what spirituality means to them personally, how this might impact on their understanding of their vocation, the doctor-patient relationship, and their patients' overall health and healing. IT members would be encouraged to develop practical tools that they and their colleagues could test and utilize. They would also fashion appropriate means to implement this within the framework and structure of the organization.

The attainment of the goals would be assessed by various inquiry devices, i.e. questionnaire, one-on-one interviews, surveys, etc., that would measure the level of awareness and understanding of the IT members regarding the role and function of spirituality in medicine; and the development of a spiritual assessment tool to be utilized in their individual medical practice.

The plan was to be presented to the Site Team in order to seek their assistance and support in identifying and inviting members of the IT from various disciplines and specialties. In the process of building the IT, it became apparent that the composition of the Site Team would be similar to the IT: Carl Flemister and John White represented the HIP officers, Beatriz Jaramillo, medical statistician, Dr. Deborah White, Physician, Reverend Felicia Thomas and Reverend Alexander, clergy and a much later addition to the Site Team, Diana Cooper, registered nurse. Nonetheless, the Site Team decided that Medical Directors from HIP medical groups would be invited and that the invitation was to be made by Carl Flemister; recognizing that he had the influence and established relationship with the medical directors through his role at HIP.

Enable and equip medical practitioners in one of HIP's medical groups integrate spirituality in their practice

Carl Flemister's participation was also necessary to facilitate the second goal. The intent was that medical practitioners would be furnished with the knowledge and skills to address the spiritual issues of patients in their care by testing and utilizing the spiritual assessment tools that the IT would put together. These medical group practitioners would participate in similar continuing education opportunities as the IT. The intention here was to equip the medical group practitioners to gain the same knowledge and understanding of spirituality in medicine and be proficient in utilizing the spiritual assessment tools that the IT will have gained and passed on. The evaluative process and criteria of the first goal would be used wherein their understanding of the

role of spirituality would be apparent in the way they would incorporate and utilize the spiritual assessment tool in their practice.

Before the IT was formed, Carl Flemister announced that he would retire that year and John White was put on board as the Managing Director of the department. Carl Flemister played a principal role in the project because of his position in the organization. He was also the only person in the organization who understood the connection and saw the importance of the D.Min. program to our work. His leaving meant the loss of access to the medical directors, a key component of this project. It must be mentioned that HIP medical groups, like the American Baptist Churches, USA, are autonomous (churches) entities with an "associational" relationship with (Valley Forge) HIP. In addition, when Carl Flemister left, the department was transferred from the Foundation to HIP's medical division, thus, losing its own autonomy as well as its unique identity. HIP's medical division wherein the Integrative Wellness Department is housed had undergone several leadership changes - at least three in the past four years. Each time, we had to educate the incumbent about the role and function of IWD; each time we lost more of the essence of its spiritual emphasis and transitioned toward operative terminologies that fit the medical model: health promotion and disease prevention, mind-body, self-care, behavior modification. The identity and guiding principles upon which the department was originally founded were changing significantly.

Amendment of the Challenge Statement Impacts on the Project Goals

Left with my own limited devices to carry out the project in a muddled environment, I began to examine my options, explore alternatives, and assess the viability

of my project within the structural and philosophical changes after Carl Flemister left. This required me to re-establish and clarify my role and function in the department, develop networks, and adjust to the new leadership. This took almost two years to work out. The formation of the Interdisciplinary Team became a remote possibility and consequently impacted upon the achievement of all of the goals envisioned at the beginning of the project. After extensive consultations both with my site team and my advisor, Lester Ruiz, it was decided that I amend the Challenge Statement. The project will continue as planned under the amended Challenge Statement and goals using similar strategies and evaluation processes, but no longer through an IT. The new vision was to create an educational curriculum that would become Integrative Wellness Department's Spirituality and Medicine program.

Shortly after I made the changes to my challenge statement, Dr. Deborah White, a member of my site team and head of the Health Status Improvement Subcommittee (HSISC) invited me to be a regular participant on the committee. This committee is composed of an interdisciplinary group of medical directors of various specialties including physicians, nurses, mental health practitioners, statisticians, HIP officers, social workers, etc. (see Appendix E Subcommittee Directory).

> The Health Status Improvement Subcommittee (HSIS) will review and monitor programs to optimize care for our Members. The subcommittee will focus on improving health for members who have chronic diseases and who are at risk for developing chronic disease.
>
> -HSISC Charter

Though my role in this group was to represent the department and primarily to report on the department's activities, I took the opportunity to use the HSISC to serve as the "unofficial" Interdisciplinary Team. At these meetings, with the approval of Dr.

White, I implemented some of the strategies of the project goals that I deemed appropriate. I distributed peer-reviewed articles and studies on spirituality and medicine, including samples of various spiritual assessment tools. Due to an agenda that was always very full, there was no time to discuss these materials, view educational videos or invite resource speakers. These educational modules that were not presented will later be offered in another setting. Instead, I solicited any comments, questions or suggestions about topics or speakers related to spirituality and integrative wellness that they would like to recommend.

As an alternative to the questionnaire to evaluate the IT's level of awareness and understanding of spirituality in healing and medical practice, I asked the questions (see Appendix C, Summary of Symposium Evaluation) at the meetings and talked to the members informally, sometimes after the meeting or when I saw them in other HIP functions. This is how I learned that most of these healthcare practitioners have very strong personal spiritual and religious convictions, and those who did not were open to learning about how they can address their patients' spiritual concerns. Though many of them expressed that they would be willing to be a part of a group (as indicated in the symposium questionnaire to be shown later in this chapter) that would work towards the integration of spirituality in medical practice, they too realized that time and validation of this type of group within the organization was problematic. Many of them called me to suggest books, speakers and other materials, or to share experiences they had in dealing with their patients' spiritual issues.

This approach proved to be more effective and less threatening than the one I had originally envisioned, and enabled me to achieve the overall goals and objectives,

implement the strategies and evaluate the project goals without having to create a formal IT group. This is where my project got the confirmation that these healthcare providers were looking for tools to assist them in attending to their patients' spiritual issues, more than they needed to be a part of a team that will embark on such an intensive undertaking within a complex setting. Even after Dr. White, who had originally invited my participation, stepped down from her post in 2005, my work continued to be a part of the HSISC.

These goals were not achieved through the organization of the Interdisciplinary Team (IT) and the implementation of the IT's findings in one of HIP's medical groups. But as mentioned in this chapter, these goals were met by the HSISC and the creation of an organized educational structure.

HIP Integrative Wellness Spirituality and Medicine: A Continuing Medical Education (CME) Program

1. Carl E. Flemister Annual Symposium on Mind/Body Medicine, Spirituality and Health
2. Continuing education program,
3. Website to post the symposium lectures and resources on spirituality and medicine, including the development of a
4. Medical Reference Manual on Religious Diversity

The Spirituality and Medicine program of HIP Integrative Wellness offers educational opportunities for HIP's providers to explore the benefits of incorporating

mind/body medicine, self-care approaches, and an understanding of spirituality and belief systems into the delivery of healthcare. The program also encompasses a growing set of partnerships with nationally recognized leaders in the field of integrative medicine.[52]

Carl E. Flemister Annual Symposium on Mind/Body Medicine, Spirituality and Health

At the annual symposium, leading experts on spirituality and health present the most recent scientific research on the biology and physiology of belief in a way that is relevant to clinical practice. Each symposium is a CME-accredited event that is traditionally co-sponsored with the New York Academy of Medicine.

The symposia presented over the last 5 years are as follows:

- Dr. Herbert Benson "The Power of Belief: The Science of Spirituality and Healing in Medicine," October 23, 2003

  Dr. Benson, a professor at Harvard Medical School, founded the Mind/Body Medical Institute. He discussed the power and biology of belief, and presented his research findings regarding how the relaxation response can influence health. A partnership with HIP grew out of the relationship established at the time of the symposium which lead to the establishment of HIP's Cardiac Wellness Program.

- Dr. Christina Puchalski "Spirituality and Health: Implications for Clinical Practice" December 2, 2004

  Dr. Puchalski, a professor at The George Washington University School of Medicine in Washington, D.C. and founding director of The George Washington Institute for Spirituality and Health, spoke about taking a "spiritual inventory" as a component of the medical history in order to help providers understand the role of faith in patients' lives.

- Dr. Harold G. Koenig "Spirituality and Health: History, Research and Clinical Application" October 20, 2005

[52] "Integrative Wellness," www.hipusa.com (accessed February 2008).

Co-director of the Center for Spirituality, Theology and Health and Professor of Behavioral Sciences and Medicine at Duke University Medical Center in Durham, North Carolina, Harold Koenig, MD presented his research on the historical relationship between religion and medicine and the impact of religious involvement on mental health, immune functioning, cardiovascular function, and survival.

- Dr. Mehmet C. Oz "The New Medicine: Alternative Therapies and Their Implications to Health Care" October 19, 2006

  Dr. Oz, Professor of Surgery at Columbia University Medical School, Medical Director of the Integrated Medicine Center, and Director of the Heart Institute and Columbia Presbyterian Medical Center in New York City, explained the broad goals of integrative medicine with examples from his clinical practice and the health care policy arena. He presented scientific evidence that favors augmenting conventional Western medical practices with alternative therapies, and showed how this approach can play a vital role in post surgical healing as well as both the acute and chronic care systems of modern medical practices.

- Dr. Andrew Weil "The Art and Science of Self-care: Implications for Mind/Body Medicine" November 7, 2007

  Andrew T. Weil, M.D., Director of the Program in Integrative Medicine of the College of medicine, University of Arizona and Professor of Integrative Rheumatology, Medicine, and Public Health, addressed the art and science of self-care and explained the concept of integrative medicine: a medicine that takes into account the whole person (body, mind and spirit), emphasizes the power of the therapeutic relationship in healing, and utilizes all appropriate therapies, conventional and alternative.

Designing the Symposium Curriculum

First, I sketched a curriculum series identifying key topics that were relevant to the information derived from conversations with medical practitioners. Each topic was designed chronologically in order to address the overall goals of this project. What I planned to do for the Interdisciplinary Team and HIP medical group practitioners was achieved by the this symposium series, introducing carefully chosen topics.

Initially I wanted to offer an introductory overview on spirituality and medicine and found Herbert Benson, M.D., founding president of the Benson-Henry Institute for Mind Body Medicine and Associate Professor of Medicine, Harvard Medical School who agreed to speak on *The Power of Belief: The Science of Spirituality and Healing in Medicine.* The purpose of this topic was to better acquaint healthcare practitioners with the relationship between spirituality and medicine, to touch on peer-reviewed scientific studies indicating the interrelationship and interaction of the mind, body and spirit and to encourage the furtherance of this subject in the healthcare industry. This symposium was held on October 23, 2003 at the Graduate Center of the City University of New York, in Manhattan.

With Herbert Benson and with succeeding faculty that I contacted, I used the internet to find their information and made a "cold" call – for lack of knowing anyone who might have any access to them. I was pleasantly surprised by their warm reception and genuine interest in the work we are doing at HIP. All five of them, to date, were happy to accommodate my invitation.

After the introductory presentation by Herbert Benson, I decided that it was time to provide medical practitioners with practical tools that they can use in their practice. I searched for an expert on spiritual assessment and found Christina Puchalski, M.D. I developed the program (course) description to facilitate the presentation of her research and engage the audience in a discussion of critical issues related to her clinical work. I requested her to explain why a therapeutic focus that incorporates a spiritual approach is increasingly seen as optimal for good patient care. I wanted practitioners to understand why the spiritual dimension of patients should be of concern in providing care; how they

can integrate spirituality into the practice of medicine; and why the issue of practitioner self-care and spirituality is important in providing the best possible care to their patients. Learning objectives for the Puchalski symposium included gaining an understanding of advances in the scientific basis of mind/body medicine, including the role of spirituality and belief in medicine; developing an awareness and respect for the individuality and diversity of patients' beliefs, values, spirituality and culture with respect to illness and its meaning, cause and outcome; recognizing the role spirituality plays in coping with chronic illness; and understanding the basis for performing a spiritual assessment (see Appendix F, A Spiritual Assessment Tool).

The next symposium was led by Harold Koenig, M.D. My intention was to help participants examine the historical relationship between religion and medicine, including the origins of indigent health care, hospitals, medicine and nursing. The course would also explore research examining the relationship between religious involvement and mental health, and propose a model of how beliefs may impact physical health through the mind/body mechanisms. The lecture would also touch upon the relationship between faith and physical health, immune functioning, cardiovascular functioning and survival. Medical practitioners would learn what these findings mean for clinicians and how they might be applied to clinical practice in a sensitive and appropriate manner.

In 2006, I invited Mehmet Oz, M.D., to serve as faculty. He was widely known as Oprah Winfrey's doctor, among other celebrity patients, regularly appearing on her show. I thought that the chance of inviting him was slim to none but like all other faculty members, he was happy to oblige. I requested Mehmet Oz to tailor his lecture around the broad goals of integrative medicine, citing examples from his clinical experience and the

health care policy arena. He would present scientific evidence for augmenting conventional Western medical practices with alternative therapies, including meditation, yoga, guided imagery, massage, aromatherapy and prayer. In addition, he would examine how these modes of therapies play a vital role in solving chronic problems in today's "acute illness care" system and their positive impact on post surgical healing. Mehmet Oz would also discuss common misconceptions about these therapies and explore strategies to transform the clinician/patient relationship into a new and "open-hearted" delivery of care.

Participation in this program was intended give attendees an understanding of: how traditional Western medicine can be optimized by incorporating alternative therapies; scientific research and clinical implications of integrative medicine; strategies and practical considerations of integrating alternative medicine into health care policies; "wellness" and the difference between "healing" and "curing" and how an integrated approach of mind/body medicine can improve the well-being of cardiac patients. Andrew Weil, M.D., like Mehmet Oz, is also a well-known figure in celebrity circles and in the field of integrative medicine. Andrew Weil agreed to my request to lecture on the art and science of self-care and how this impacts on the overall health and healing of patients and medical practitioners alike. I asked him to provide resources and show physicians and health care practitioners how to help patients learn how to heal and stay healthy on their own. Andrew Weil would also speak on the future of medicine that takes into account the whole person (body, mind and spirit), including all aspects of lifestyle, emphasizing the therapeutic relationship that makes use all appropriate therapies, both conventional and alternative.

In this case, the program objective was to give participants the understanding of: self-care as a necessary component in achieving optimum health; the role of physicians and other healthcare practitioners in integrating self-care in their practice; self-care as a proven component of addressing disease and how it encourages compliance and promotes a positive doctor-patient relationship; as well as to look at the future of medicine as it reclaims the art of healing and restores its focus on a more integrative approach to health care.

Creating the Educational Infrastructure of the Symposium

Building the infrastructure of the symposium is a tedious, detail-oriented process. From developing the budget to staffing; from identifying and enlisting appropriate departments to work with, i.e. legal, marketing, Medical and Quality Informatics to filing Continuing Medical Education (CME) accreditation, etc., to creating policy and procedures. Curricula has to be drawn, informed by the knowledge of the need of a target audience. The faculty are identified: In this case, someone who is also a physician as the audience will only be receptive to peer-reviewed materials or respected colleagues. A letter of agreement has to be drawn and approved by the legal department, specifying agreed topic, honoraria, travel and lodging arrangements, etc. In addition, a contract from the speaker has to be reviewed by legal and signed by both parties.

After the faculty signs the letter of agreement and the contract agreed upon, an application for Continuing Medical Education (CME) credits is filed with the appropriate accrediting body. I chose the New York Academy of Medicine to provide the physician accreditation and, for the nurses, the HIP Health Plan of New York, which has been

approved as a provider of continuing education by the New York State Nurses Association (an accredited approver of the American Nurses Association and American Nurses Credentialing Center's Commission on Accreditation. This application is a highly involved process dense with policy and procedures, forms, supporting articles, approval process, signatories, fees, etc. (see Appendix G, CME Application).

A brochure was developed containing the following information: registration form, faculty introduction, program description (describing the content of the lecture), learning objectives, accreditation, disclosure policy, program agenda, etc. (see Appendix H, Annual Symposium Brochures). The Registration is made available online, by mail, fax and telephone. The online registration is worked out with the Internet Technology department. A process is set up that includes sorting responses according to profession: doctors, nurses, allied health professionals and other; a letter of confirmation, containing a confirmation number, is created and sent accordingly. For the faculty introduction, the speaker furnishes us with their photograph and curriculum vitae. Upon receipt, this document is edited and sent back to the faculty approval.

I also developed the program/course description and learning objectives. These documents also go through a series of editing and an approval process between HIP and the faculty. Consequently, an accreditation application is filed with a CME accrediting body (see Appendix G, Clinical Medical Education (CME) Application) and a disclosure policy is supplied by the accrediting body and printed in the brochure.

Other components in this process included:

- Putting together a training packet containing the following: Verification of Attendance form from the accrediting body, evaluation forms, supporting peer reviewed materials that are researched and bought from the publishers.

- Book signing if faculty agrees to do a book signing, books are ordered from the publisher, book signing is scheduled and arranged with the faculty and event is promoted.

- Venue is reserved and caterers are contacted to send their proposals. Menu is planned to accommodate Kosher meals and dietary restrictions of attendees.

  - Photographers, videographers are hired and contracts processed.

  - Give-aways are ordered according to guidelines of accrediting body.

  - A post symposium process is set up that includes the compilation of forms, hiring a writer to write the summary, prepare the video for the web conversion, etc.

  - A medical writer is hired to write a summary of the symposium. The summary also goes through the approval process for CME and after approval is sent to all of the providers in the HIP network (see Appendix L, Spirituality and Medicine Symposium Summary).

Documenting and Disseminating the Knowledge and Findings of the IT

The third goal was to document and disseminate the knowledge and findings of the IT through medical and generic publications and other forms of media. This goal aimed to provide medical practitioners with peer-reviewed studies, educational resources and tools that would enable them to integrate spirituality in their practice as well as have enough basis to pursue a clinical study that would deepen their knowledge around the interactions of mind, body and spirit in health and healing.

In pursuance of this goal, I had planned for a writer to be hired to work with me in developing a manual containing a step-by-step process of how spirituality was integrated in the practice of medicine at one of HIP's medical groups. This was to include a copy of the spiritual assessment tool and directions on how to use it as well as other pertinent information, like a list of hospital chaplains and their contact information in the greater

New York area, articles, and other resources. The manual would be published and circulated in various ways: HIP website, continuing education events, HIP publications and at other medical group gatherings.

Once again, a questionnaire would be used to survey and measure the outcome of the utilization of the spiritual assessment tool and the manual; quantify whether the doctor/patient relationship has improved; assess medical practitioners' level of ease in dealing with patients' spiritual issues and be able to acknowledge how their own spirituality impacts on their vocational and personal life.

Because the formalized IT and medical group implementation of my goals became impossible, this goal too had to undergo revision. Then resource manual for spiritual assessment had to take a different form.

I created an initiative in response to the Carl E. Flemister Symposium evaluation/survey of HIP providers for tools that would assist them in addressing the religious and spiritual needs of the HIP members that they serve. These surveys, conducted consecutively for three years consistently indicated the need for spiritual assessment resources (see Appendix C Symposium Evaluation/Survey).

The Tanenbaum Center for Interreligious Understanding

Because I could not justify the hiring of a writer for my project I looked to the Tanenbaum Center for Interreligious Understanding (Tanenbaum) to produce a manual – this time on the various religious traditions' prescriptions for health. Tanenbaum came to HIP with an offer to provide cultural and linguistic diversity training in the workplace. They first approached HIP's External Affairs department who in turn referred them our

department. I was put in charge of this initiative – responsible for developing appropriate programs for the whole organization and the Integrative Wellness Department. I facilitated the establishment of a continuing education program for HIP employees as well as the Integrative Wellness volunteers. Plans to roll out this training program to HIP medical groups are in the works. I also took this opportunity to propose the creation of a manual for our medical providers.

Medical Reference Manual on Religious Diversity (MRMRD)

The initiative is comprised of two major components: Medical Reference Manual and Training, plus ancillary materials. The MRMRD will be a binder of materials that can also be a stand-alone reference text. The binder format allows easy updating without the need to reprint the entire text.

This user-friendly resource includes both information that can be quickly referenced for immediate, practical answers as well as material that offers more in-depth knowledge and the ability to acquire skills and do self-assessments. It is designed for busy doctors and nurses, and will detail ways in which providers can address religious issues even when pressed for time. (As providers become more religiously competent, they will reduce religious tensions and avoid miscommunication; as such they will become more efficient and be able to spend more quality time with each patient). The manual is also designed to apply to a wide variety of settings and providers, from hospitals and residential care settings to private and group practices, as well a to a range of healthcare providers from physicians to nurses' aides and administrators. Physicians and nurses are obvious target audiences, but the materials will also be useful for nurses'

aides, patient advocates, nutritionists, mental health professionals and allied health professionals.

The Medical Reference Manual on Religious Diversity includes: [see Appendix K, Medical Reference Manual on Religious Diversity Content)

Chapter I. An Introduction to Religion and Healthcare
Chapter II. How to Understand Your Patients
Chapter III. Religions of the World and Their Applications to Healthcare
Chapter IV. Providers' Responsibilities
Chapter V. Key Interventions

The MRMRD Process

A 12 to 16 month process would enable the Tanenbaum Center to work with HIP to create and Advisory Council for the project, research and develop initial drafts of the materials, collaborate with the Advisory Council, the Working Group and HIP affiliated professionals on language, field test sections as appropriate, collaborate with HIP designers and production staff, design a marketing and dissemination plan with HIP, and disseminate the manual:

1. Create and convene Advisory Council and Working Group.

The Tanenbaum Center and HIP will be guided throughout the writing and production process by two teams of experts. The Tanenbaum Center and HIP's Integrative Wellness Department will work together to identify, conduct outreach and invite members to an *Advisory Council* and a *Working Group*.

- The *Advisory Council* will be a group of approximately eight highly regarded experts in medicine, religion and cultural competence/interdisciplinary relations. The Advisory Council will be a high-level group who will be convened periodically by phone (or contacted individually) to comment on the direction of the project. Specific Council members may also be asked to review segments of

the handbook in which they have particular expertise. In addition, their names will lend credence to the project.

- The *Working Group* will be a slightly smaller group of five or six practitioners to that will be identified jointly from Tanenbaum Center and HIP contacts in the New York City areas. The group will seek to include a variety of providers: physicians, nurses, and cultural competence professionals. This group will be more intimately involved in reviewing and field testing the materials as they are produced, and will be convened several times throughout the process to offer detailed feedback.

2. Finalize overall concept and outline of manual with Advisory Council and Working Group.

A consultation with Tanenbaum Center, HIP's Integrative Wellness Department and both the Advisory Group and Working group will be conducted to review, enhance and refine the topic and format outlines detailed above.

3. Complete first draft of manual text and ancillary materials.

Given the sensitive nature of the topic, the Tanenbaum Center will undertake the research and drafting of the first draft of all materials in the manual. The Tanenbaum Center's existing materials and curricula will be supplemented and expanded with original research and with the new data will serve as the basic foundation from which the manual will be created.

4. Review first draft with Advisory Council and Working Group.

The Tanenbaum Center and HIP will work with both groups to review the working drafts. Advisory Council members may be asked only to look at portions for which they have particular expertise, while Working Group members will be asked to conduct a more detailed analysis of all the materials.

5. Revise Text.

In light of the input from the various interested parties, the Tanenbaum Center will revise the text, possibly with freelance writers brought in by HIP.

6. Field test with working group.

HIP and Tanenbaum Center will work with the Working Group members to outline a plan for field testing of the various components through their provider contact. The design of the field test process will begin simultaneously with revision of the text. Field testing may include, but not limited to:

- Providing the handbook to physicians and nurses who have not been involved in its development to get their feedback.
- Providing the ancillary materials to doctors' offices, institutions and group practices with instructions on how to use the case studies, charts and other materials to test their reactions to the materials and the responses that they receive.
- Interviews with participating testers to gauge the utility of the materials.

7. Complete first draft of design.

The working drafts will be provided to design person/team as field testing begins so that they can create prototype of the binder and tabs, ancillary materials and container for the completed manual. If an online version of the toolkit is contemplated simultaneously, web design should also begin at that time.

8. Revise materials in light of field testing.

Using tester's evaluation comments, the Tanenbaum Center, HIP and any affiliated writers will make a final revision to all components of the manual. Comments concerning usability of design will be forwarded to the design team.

9. Finalize design.

The Tanenbaum Center and HIP will provide the final test to the design team. If an online version is being created, the final test will also be uploaded to the site. Finalized design of the manual components will be provided to the Advisory Council for a final review.

10. Develop Marketing and Dissemination Plan.

The Tanenbaum Center and HIP will collaborate to develop a plan to publicize and disseminate the manual. This plan can be developed simultaneously with the finalization of the text and design above.

11. Complete production and begin dissemination.

Using HIP's production capabilities and provider network, the toolkit will be produced, publicized and disseminated through the greater New York area. Any manual-affiliated training sessions will begin. If a web-based version is created simultaneously with the print version, the website will go online at that time as well.

The World Wide Web and Other Forms of Media

In addition to the Medical Reference Manual on Religious Diversity, HIP providers are able to access resources for integrating spirituality and medicine on the HIP website, where information from all of the symposia, including video of the lectures, are

available. The symposium lectures, summaries and other resources including related links are disseminated through the www.hipusa.com. HIP newsletters that go to the entire network providers, members, medical schools, other related organizations and volunteers also include information on the Integrative Wellness Department and the Spirituality and Medicine program (see Appendix I, Newsletters).

An online version of the MRMRD will be made available where users will be able to access quick reference guides, templates for spiritual assessments, self-assessment tools, as well as a searchable database of information on the didactic materials, and much more.

Continuing Medical Education (CME) Program

The Continuing Medical Education (CME) Program, geared toward the integration of spirituality in medicine, is offered quarterly for HIP employees, medical practitioners and Integrative Wellness volunteers. The process is similar to that of the annual symposium only on a much smaller scale. Classes are composed of no more than 100 participants depending upon subject matter. If the courses are more interactive, breakout groups are formed. The CME offerings are also offered via tele-conference to other related/affiliated sites within HIP.

Further research on the impact of training of HIP medical group practitioners on spirituality and medical practice and utilization of the spiritual assessment tool

This goal sought to provide medical practitioners and other related organizations access to a scientifically-based clinical trial of the spiritual assessment tool by developing

appropriate methods of implementation and documentation as well as dissemination of these trials.

Although the actual trials of the spiritual assessment tool and measurement of these trials were not done because of the eradication of the IT, the process has been established so that anyone interested can begin doing in-depth studies if they so desire.

Develop a new paradigm for the integration of spirituality and medicine

The primary objective was to create a vision of what it means to be a medical center that offers an integrative wellness approach to care that could be communicated to providers; and a replicable model of integrative care that would be reproduced in multiple medical centers. This goal's implementation was to involve producing a manual that would serve as a primary resource.

The Tanenbaum MRMRD and the resources for providers on the HIP website are a good start toward the achievement of this goal. The new paradigm is developing along with a vision for developing and providing training and resources for Integrative Wellness Centers. The vision is complex and multifaceted, because the spiritual dimension as defined in this project is far-reaching. It ranges from integration of care between medical specialties, to providing therapies that have originated in diverse cultures (like acupuncture and herbal therapies), to training medical providers to understand various religious perspectives and their impact on health and healing, to teaching a framework for understanding the function of prayer in a medical setting, and providing training and empowerment for people who are dealing with chronic disease.

One of my new goals is to take the resources I have obtained through my work at HIP and make them available to local communities, creating a non-profit organization that will resource and link religious organizations, physicians, and medical centers into an integrated community of care. This non-profit organization will help to restore in a very practical way the connection between medicine/science and religion/spirituality that our culture historically has broken apart; reconnecting spirit, mind and body in a new and practical way on the community level.

CHAPTER VI

In Summary

Fulfillment of the Project

The project was rather ambitious and almost impossible to implement given the organization's eventual structure and my place in it. But looking back at what transpired in my six years into this program, through all the organizational changes, challenges and obstacles as well as the amendment of the project's Challenge Statement, I realize that all the goals and plans of this project were achieved in one form or another. As I reflect on everything that happened and what this project has contributed to my setting, I am deeply humbled. Humbled by the power of God who is not mocked by powers and principalities, by my own vanity in thinking I could pull this off by myself, by others who doubted and felt threatened by this project. Gleaning inspiration from the faith of the woman in the text…if I could only touch the tip of even a few medical practitioners' stethoscopes, I know that I will be able to affect a kind of healing in the delivery of medical care where the spiritual component of an individual is given equal attention and care as the emotional and physical; where an interdisciplinary approach is a preferred method of delivering that care. The interdisciplinary approach allows for a more holistic approach, more encompassing of the individual's totality, not just part and parcel of the whole.

God's hand in this project can be seen in the HISC when it was not possible to organize the Interdisciplinary Team; in the Tanenbaum Center for Interreligious Understanding that facilitated the development of the manual and provided yet another interdisciplinary group through the Advisory Council and Working Group who are highly regarded experts in the field of spirituality and medicine. When it was no longer feasible to involve medical practitioners from HIP's Medical Groups, I do believe that God made it possible to put into practice the spiritual assessment tools through the field testing component of the MRMRD.

Through the symposium curriculum, God provided resources far better than what I initially envisioned with the Interdisciplinary Team. God sent the best of the best as faculty when I thought it was impossible to penetrate the "crowd" or mob that surrounded them.

When the plan of enlisting one of Hip's Medical Group's participation in this project was eliminated, God presented a more vast and expansive medium to disseminate the information, not just to a few practitioners in a medical group but to the World Wide Web! As if witnessing a miracle happen, God created the Medical Reference Manual on Religious Diversity.

Transformation

The story of Jesus and the woman with the hemorrhage illustrates a key principle of transformation and change. It is seldom a single transaction in one direction. Transformation is often multi-dimensional and reciprocal. When the woman was healed

of her infirmity as she touched Jesus, the Lord was also affected. He felt a force leave him. Transformation may be two-way.

The project which was initiated within HIP had several repercussions and ramifications. The Department of Integrative Wellness, founded on the premise of the interconnection of mind, body and spirit, is fully established within the organization of HIP. Its influence is diffused throughout the corporate structure. Most of the staff in the network are aware of the department's work on spirituality and medicine, and may have been touched by its outreach.

The department has several accomplishments that have benefited the larger organization in tangible and intangible ways. The work of the department has contributed to membership retention through its positive impact on member care. The department has produced excellent public relations for the organization. Many members, and even those outside the organization, have been impressed that HIP had adopted a holistic approach to care and had been receptive to the benefits of an inclusion of spiritual care. Since the intersection of health and spirituality has become mainstream, and since HIP was the first HMO to incorporate the recognition of the integration, the corporation was viewed as modern and progressive.

The organization could also recognize a return on their investment in the department. Studies indicated that the health of members was improved by a multi-faceted approach, avoiding costly health issues and speeding recovery from treatment. As the department worked with the medical providers, relations were improved between the company and the care providers. Providers could feel that the insurer was offering a

service that would strengthen their practice and providing an expanded array of instruments that would be available to them.

The department's programs expanded the connection to the communities in which the members were served. The services gave name recognition and positive feedback from the recipients. And the department's programs, coordinated with other treatments, contributed to a higher quality of service to the membership.

The department has transformed the relationship with providers as it has transformed their outlooks and approach to care. Practitioners, as a result of the department's work, have a new awareness of the possibilities for integrative wellness. They have enhanced information and resources in addition to the raised consciousness. Practitioners have become knowledgeable about skills and tools that can be used in alternative or supplementary treatments. They are acquainted with resources and training options for the integration of spirituality.

Before the project, practitioners were resistant to the consideration of spirituality, mostly due to the lack of familiarity and training in the field. Prior to the department the doctors did not have a forum for dialogue, inquiry and study in relating medicine and spirituality. Spirituality had not been factored into the healing regimen before its introduction through the department.

Because of the practitioners' new regard for an expanded approach, the relationship between doctor and patient has improved. The doctors and members are more favorably connected to HIP, since HIP has enhanced the options for treatment. Because of the receptivity of practitioners, there is a new basis for further research. The studies of the effects of integration can be expanded.

Before, doctors and chaplains had been defensive and territorial, suspicious of the other's role and expertise. Chaplains were wary of hospital volunteers as competitors. The program has changed perceptions, so chaplains now see the volunteers as those who improve their patient care and their relation to the hospital. The program and project have fostered a working relationship between chaplains and the department, to the point that some chaplains have been active in the supervision of volunteers. Some have also aided the volunteers in orientation and access to the system.

The relationship between doctors and members was enhanced by the work of the department. Members may expect an integrated approach to their medical care, a holistic approach that incorporates spirit, mind and body in the appraisal. Caregivers are now equipped to deal with some spiritual issues in relation to the healing. As the integration ensues, members are more comfortable in communicating with the doctors about their spiritual concerns. Dialogue has been facilitated by a mutual awareness that the spirit is a legitimate ingredient of human health.

Transformation may occur in the spiritual institutions as well. A recent National Council of Churches study has revealed that a large number of churches are now engaged in programs for medical care for members and community[53]. The work of the project and the department has facilitated the introduction of such ministries into the life of the congregation. Many of the programs in the department are easily exported and adopted to the ministry of religious organizations. Churches could benefit from the department's work (e.g. training church leaders for hospital visitation). Churches may have been as suspicious and territorial as the medical practitioners. The publicized integration of the

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physical and spiritual healing encourages a tolerance--even a collaboration and partnership--in the care of the people.

Transformation was also personal. As I interacted with practitioners, I sought to avoid the relationship dynamic that the doctors had with the corporation. Instead, I would be a "spiritual doctor," one who would enable, equip and empower them to serve their patients. The task was to embody and exemplify what they should be for their patients. They looked for someone to care for their concerns, to show understanding and compassion. My approach was analogous to their methodology--an exam that factors physical and spiritual symptoms. How can a doctor listen for the pathologies that might reveal spiritual concerns? What is the "stethoscope" or "thermometer" that would detect spiritual issues? The challenge was to help the practitioner identify the appropriate protocol for healing the whole person. The medical provider would also be trained in referral, treatment and prescription for the strengthening of the spirit and the treatment of the problems.

The project and department brought transformation to the practitioners, the corporation, the members, the department staff and religious agencies. There has been a new appreciation of the interaction of mind, body and spirit, and an introduction to the training, resources and information that are valuable in the shared holistic treatment of illness. As the different parties grow more comfortable in their respective roles and more aware of the potential contribution of others, greater understanding and interdependence will foster and facilitate more complete well-being. The widespread acknowledgment of the necessary integration insures that the respective camps can never ignore each other again. The cooperation is healthy.

The road ahead is long but I believe that this project has made some significant inroads and on the horizon I see a healthcare system where spirituality is integrated in the life of the institution both internally and externally with staff members; where the spiritual concerns are as important as the premium; where spiritual care is part of the prescription or protocol for health; where spiritual care is as vital to the organization as marketing and finance; where spirituality and science are once again inextricably bound together.

CHAPTER VII

Continuing Agenda: And So It Goes . . .

The inability to infiltrate the HIP medical groups forced me to consider a wider application of my original intention. When my initial project was thwarted, it was necessary to broaden the scope of the interdisciplinary integration. This impacted the future as well as the implementation of the project in the present. If the possibilities within HIP are limited, then the outgrowth of the project may lie in a more universal approach. Roadblocks and obstacles in the contained context resulted in a detour that led to a wide-open landscape of options for ministry.

Thus, my own ministry down the road may move to an exploration of initiatives outside of the particular corporate structure of the one company. The concepts and programs are mobile, able to be transplanted and instituted piecemeal (ala carte) or linked within small or large entities. My vocation might be fulfilled in coordinating a series of alternative treatments within a corporate framework, in designing integrative programs or in providing specific ministry as one of several treatment modes. My ministry could be administrative, in coordinating the various methodologies, or directing service in pastoral counseling, or teaching in seminaries and medical institutions.

Whether administrating or counseling, I would have a wide choice of venues. The changes at HIP altered my focus. But the field has grown, not shrunk. Foundations, churches, schools, wellness centers, retreat centers, spas, convention centers, medical

groups, corporate centers, commercial offices all become potential sites for integrative wellness. The resources can be marketed to insurers, practitioners, and clients in all three fields of application—medicine (body), religion (spirit) and psychiatry/psychology (mind). Practitioners in each of these three major disciplinary areas can be persuaded that their service is enriched and enhanced by collaborative practice with the others. And along the way there will be a need to chart outcomes.

As the value of integrative wellness grows in acceptance, there will be a need for creative applications in varied settings (e.g. how does a small church apply holistic health to its ministry in contrast to a hospital or an industry)? The potential to explore and introduce other programs and services are greater (e.g. offer CPE to medical practitioners who are interested by collaborating with the HealthCare Chaplaincy, Inc., expand the Continuing Medical Education Curriculum, create a chat room on website where medical practitioners can raise their issues, questions, concerns around spirituality and medicine and establish a national conference on spirituality and medicine in collaboration with other sponsors. In addition, Integrative Wellness with its spirituality and medicine programs, is now equipped to resource Medical Groups, Religious Communities, medical facilities, Schools, and I dare say, Seminaries as well as other related organizations.

What are the implications for referral, confidentiality, education, training, continuing education, accreditation, licensing, reporting, evaluating respective regimens and treatments, litigation? As the concept of integrative wellness becomes mainstream, rather than pioneering, there will be more opportunities for advocates and those who can bring the respective fields together in dialogue and service.

Given the organizational changes HIP faces right now, there is a new challenge to ensure the continuance and enhancement of these programs. There is a real possibility that Integrative Wellness Department may not be a part of EmblemHealth, the new for-profit company. If this ever happens, medical practitioners can potentially lose the resources this department has worked hard to provide. Advocacy and strong representation of the department at the negotiation table is critical. If we are successful and the department continues to have its place in the organization, further research on spirituality and medicine will be initiated. The infrastructure will be strengthened to support the expansion and enhancement of the programs. Other programs and educational modules will be developed and established: offering Clinical Pastoral Education training, training in Integrative Medicine in collaboration with Dr. Andrew Weil, endowed professorships in New York medical schools, established Integrative Wellness in HIP Medical Groups, a chat-room for medical practitioners to air issues, concerns, questions, etc.

This project has opened a whole world of possibilities and opportunities for ministry. Integrative Wellness is set up to run as an independent, non-profit organization that can continue to resource not only HIP but other health insurance companies as well. Whether the department will continue to be a part of EmblemHealth or not, this project has presented the potential to bring this ministry outside of HIP. A training curriculum can be developed not only in medical schools but churches and other religious institutions. A curriculum that includes training on self-care along with a theology of health and healing would be appropriate for seminaries. This will work toward

enhancing the health of clergy and equip them to integrate this knowledge in their ministry.

CHAPTER VIII

POSTLUDE: A Theology of Health or A Healthy Theology

The project undertaken was purposely non-sectarian. It was intentionally nonreligious, because it would need to be appropriate and applicable in the widest community. That population would include those of disparate religious persuasions as well as those who claimed to have no religious affiliation or allegiance at all. Those in the proposal could be avowed atheists, agnostics, deists or any one or more of the recognized religions of the world. Belief in God was not a requirement, since the concept of spirituality is more universal than faith in a deity.

My own personal theology did not determine the direction of the project. The project could succeed (or fail) regardless of the underlying theology of the participants, practitioners and planners. The basic tenet is that everyone has a spirit--an animating or vital principle that provides life to the organism. It is the sentient, intangible, immaterial component that influences the values, virtues and character. Almost indefinable, hard to put a finger on, difficult to describe, the spirit is nonetheless crucial. The spirit is the locus of the human hope, aspiration, despair and existence. It distinguishes us from the rest of creation, providing us with a yearning for meaning and higher purpose. That spirit is a source of potential, for it permit's the person the possibility of becoming more. Thus, there is a sense of becoming something else.

The spirit is the center, the inmost part, of human beings. It is usually seen in contrast to the body and material. It distinguishes human beings from corporeality. It may include the powers of will and decision, of intellect and reason, and feelings of value

and meaning. The spirit is aware of itself. That selfhood is called forth by others and is nourished by intercourse with the other spirits. In community we exist as "members one of another." (Romans 12:5). This selfhood is subjective.[54]

Spirit is what makes me unique, the essence of who I am. It encompasses every facet, every complex combination of experience. The spirit includes my gender, nationality, age, marital relationship, birth order, family dynamic, medical history, etc. It is hard to articulate. Like an abstract painting, it means different things to different viewers.

Religion may only shape the form of the spiritual malaise that afflicts the patient. For example, a person steeped in a sense of sin and guilt may find relief in a remedy that includes forgiveness. One trained in a social gospel may find release in involvement and mission. The practitioner seeking to treat the patient needs to be aware of the religious roots within the patient's disease. That information may guide the subsequent referral. Knowing a patient is Catholic may lead you to summon a priest. The religious background, like the patient's medical history, is valuable in diagnosing the spiritual pain and disease and in identifying the appropriate resource for healing.

The place of a theology in such a framework is difficult to assess. The work in integrative wellness is not dependent on a person's theology, for it addresses the spirituality as it is in the patient. God, in this context, may or may not be able to heal disease. Disease may or may not be a punishment for sin. Disease and crisis may or may not strengthen an individual. Such crises may or may not be valuable to growth and maturation and discipline and self-understanding.

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[54] Gordon D. Kaufman, *Systematic Theology: A Historicist Perspective*, (New York: Charles Scribner's Sons, 1968), 228.

The spirit can be sick, and that can work in conjunction with the mind and body. Therefore, treatment must be coordinated. All three aspects of the being must be assessed and addressed if we believe that people should be healthy and well and whole. Just as the spiritual aspect needs to be addressed, it is in the doctor/patient relationship that this kind of healing can transpire. This relationship requires that there be a dynamic partnership and a mutuality between practitioner and patient or caregiver and care receiver. The traditional "I am the doctor, you are the patient and I know how to fix you…" can not create this type of healing context. This way, the patient or care receiver becomes an active participant in the healing process. The power dynamic between doctor and patient is transformed into an authentic relationship where both caregiver and care receiver experience healing. The role of the practitioner or caregiver is to be sensitive to and bring into conscious awareness the resources that each individual has or needs to develop in order to create healing and wholeness.

Personally, I believe in a God that desires health and well being and wholeness for creation. That God, in my estimation, is present in all of the processes and procedures that serve to cure and heal, strengthen and comfort. Even more, that God empathetically shares our disease and suffering. That God is operative in the medical, the psychiatric and the wider spiritual community to affect treatment. God may be discerned in the caregiver, the support group, the practitioner, the technology, the drugs, the protocols, and the alternative methods that help and heal. So the task is to get the instruments and agencies that might be effective to collaborate in the treatment. We must build, equip and train a healing community that will facilitate an integrative approach to health that includes mind, body and spirit.

The project was designed to equip medical practitioners to acknowledge, respect and respond to the sources of pain and illness, including the spiritual source. The medical community needs the tools and instruments to detect spiritual illness and the resources accessible to treat the illness, even if that is another referral. The medical practitioner needs at his or her disposal an array of resources that will work to heal mind, body and spirit. But that practitioner must be willing and able to discern a spiritual component and know where to go for assistance.

The volunteers who served as pastoral visitors helped people to explore their own spiritual resources. This may include talking to a good listener, meditating to gain enlightenment, focusing on sacred or secular texts, praying for the best possible outcomes, and connecting with a faith community or support group. The department seeks to enable people to tap their inner resources for their own health. Practitioners must know whatever the patient believes can make a difference…yoga, alternative medicines, prayer, whatever.

How is the diagnosis made? Active listening. The pathology may be worry, frustration, abandonment, neglect, anger, despair. The prescription may be hope, companionship, empathy, etc. The spiritual practitioner removes the harmful ingredients. Sometimes the sharing itself is therapeutic, if the listener authentically cares. Doctors can be taught to listen and resources can be recommended for the doctors to utilize.

My own experience with my family and culture, some of which was mentioned in the body of the paper, has given me a specific belief in the role of God in health. Because of my own observations, I would contend that God fosters and facilitates healing in some instances. God also allows pain and illness in others. God sometimes provides

resources, comfort and relief, and even release. It is God who provides strength and maturation through the suffering, and God who compassionately feels our pains. God seeks healing and healers and the wide collection of tools to benefit our well-being. God has created the mind, body and spirit, and looks for their unity and integration. God's generous grace underlies our efforts to bring health and wholeness.

Spirituality is discovered and expressed in relationship, in listening moments, in the intangible expressions of emotion. Spirituality thrives in supportive community, where there is tolerance, respect, trust, a safe place to dialogue, study and acknowledge our pain and suffering. God desires wholeness. So the mission and ministry of Jesus is unity, community, oneness--so we all may be one. This is the ultimate integration.

APPENDICES

APPENDIX A

Integrative Wellness Brochure

APPENDIX B

HIP Organizational Chart

APPENDIX C

Summary of Symposium Evaluation

APPENDIX D

Professional Experience

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APPENDIX F

A Spiritual Assessment Tool

APPENDIX G

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Summary of Assessment of Candidacy Competency

APPENDIX K

Medical Reference Manual on Religious Diversity Contents

APPENDIX L

Spirituality and Medicine Symposium Summary

BIBLIOGRAPHY

"About HIP" www.hipusa.com (accessed April 2004).

Benson, Herbert, M.D. "The Affiliate Program of the Mind/Body Medical Institute." Brochure, 2003: 6.

Blass, John M.D. telephone interview by author, 12 September 2003.

Carey, Benedict. "When Trust in Doctors Erodes, Other Treatments Fill the Void." *New York Times,* 3 February 2006.

Cobb, Mark, Jane Dyson, Dawn Forman. "The Meaning of Spirituality: A Literature Review." *Journal of Advanced Nursing* 26, (December 1997): 1183-88.

Conn, J. W. in *The New Dictionary of Theology*, (Collegeville, MN: The Liturgical Press, 1987).

Dalzell, Michael D. "Pastoral Service Renews Meaning of Faith in Medicine." *Managed Care*, March 1998: 30B-E.

Flemister, Carl E. interview by author, September 2003.

"The George Washington Institute for Spirituality and Health." http://www.gwish.org (accessed February 2008).

"GHI History." http://www.ghi.com/default.aspx?Page=8 (accessed February 2008).

Grant, Frederick C. *The Interpreter's Bible Vol VII.* New York: Abingdon Press, 1952.

HIP Health Plan of New York Preventive Health Sub-Committee meeting. Deborah White, Chair, January 16, 2003.

HIP Medical Director. HIP Spirituality and Medicine Initiative Committee Meeting, New York HIP Headquarters, 21 March 2003.

"Integrative Wellness," www.hipusa.com (accessed February 2008).

Kalb, Gloria. "Faith and Healing." *Newsweek*, 10 November 2003, 43-46.

King, Dana E. *Faith Spirituality and Medicine: Toward the Making of the Healing Practitioner.* Binghamton, New York: The Haworth Pastoral Press, 2000.

Koenig, Harold, G.. "Religious Perspective of Doctors, Nurses, Patients and Families." *Journal of Pastoral Care* 45, no. 3 (1991): 254-67.

Kushner, Harold. *When Bad Things Happen To Good People.* New York: Avon Books, 1981.

Lane, Nancy, Ph.D. http://www.ahealingministry.com/workshops-6.html (accessed April 2004).

Levin and Vanderpool. "Religion and Medicine: How are They Related?" *Journal of Religion and Health* 29, no. 1 (March 1990): 20.

Oz, Mehmet. "Heart and Soul: The Integrative Medicine of Dr. Mehmet Oz; Unedited Interview." http://speakingoffaith.publicradio.org/programs/heartandsoul/index.shtml (accessed January 2008).

Puchalski, Christina. www.christianhealth.co/connect/007, (accessed April 2004).

Puchalski, Christina. www.healthatoz.com/atoz/news/uwire, (accessed April 2004).

Remen, Rachel Naomi. "Recapturing the Soul of Medicine: Physicians need to reclaim meaning in their working lives." http://speakingoffaith.publicradio.org/programs/listeninggenerously/remenarticle.shtml (accessed February 2008).

The Revised Standard Version of the Bible.

Sanome, R. A. et al. *Academic Psychiatry,* 1990, 434-38.

Time, 24 June 1996.

USA Weekend, 5-7 April 1996.

Warner, Jennifer. "What Do Patients Want?" *CBS News 60 Minutes*, 11 March 2003.

"Welcome to HIP USA.com." http://www.hipusa.com (accessed February 2008).

"What is Clinical Pastoral Education?" www.acpe.edu (accessed February 2008).